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MYTHS IN MENTAL ILLNESS SCALE: PRELIMINARY STUDY AND PSYCHOMETRIC PROPERTIES

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ABSTRACT

Introduction: due to its inherent characteristics that interfere in psychological, social and occupational functioning, it's difficult for society to understand them. In the past, they were related to esoteric components. Given society's lack of understanding about these diseases, stigma is a current reality, with many myths that are associated to them.

Objective: to evaluate the reliability and validity of the Myths in Mental Disorder Scale and the myths in Portuguese society associated with mental illness.

Method: this is a quantitative, methodological, cross-sectional and descriptive study with a sample of 394 participants from Portuguese society. A sociodemographic questionnaire and a scale on myths in mental illness were applied, both developed by the authors for the present investigation. It was intended to verify the existence of biases related to myths in different groups, between genders, for example, who have suffered or not from mental illness, worked or not in the area of mental health, and who has a family member with mental illness.

Results: there were statistically significant differences between genders (t=-2.004; p=0.05), with men that have more associated myths than women; and in the work area (t=-3.591; p<0.001), who works in the area of mental health has fewer associated myths.

Conclusion: the results indicate that people who do not deal with mental illness in their profession have more myths associated with mental illness, and it is emerging the implementation of strategies that aim reducing the myths of the population, thus reducing the associated stigma and the consequences on the rehabilitation of the person with mental illness.

Keywords: mental disorders; social stigma; mental health; validation studies; psychometrics.

INTRODUCTION

The history of mental illness has been reported since the dawn of civilization, with countless records, some from the past millennium, where it is assumed to be madness or insanity[1].

Madness, which until the 5th century BC was associated with esoteric and spiritual explanations, such as possessions and magic, was later perceived based on a medical model, by Hippocrates, in Ancient Greece, who tried to analyze the less adjusted behavioral changes[2]. Later, in the Medieval era, the Church was the intermediary between God and man

and madness was associated with demonic possession. If the madman confessed to being a wizard, he could be exorcised or severely punished. If he belonged to the upper class, he could buy the Holy Inquisition and was considered just an 'eccentric'. At that time, the insane were heretics. In turn, the 17th century was marked by "scientific rationalism", and madness began to focus again on the individual's loss of reason, will and moral misfit, with the creation of asylums[3].

In the 18th century, humanization of care for mental illness began with the implementation of a model created by Phillippe Pinel (1745-1826), in France. This model was first applied at Hospital Bicêtre (for men), and later at Hospital da Salpêtrière (for women), and it has become innovative and striking to remove the chains of patients[4].

Only in 1951, pharmacological treatments were put into practice, based on studies carried out by Emil Kraepelin (1856-1926), the father of psychopharmacology, a fact that became significant in the treatment of people with mental illness from that time on[5].

In the 20th century, Eugen Bleuler and Jung, based on Freud's Psychoanalysis, promoted the psychoanalytic movement that proposed the definition of mental illness as being a state of affective disorders. Concomitantly, Freud stated that anyone could, at some point in life, develop a mental illness[6].

In Portugal, until 1848 the "mad people" were placed at the Hospital de São José in Lisbon and at the Hospital de Santo António in Porto. However, from this date, specific institutions were created to welcome and to treat people with mental illness, namely Hospital de Rilhafoles (later called Hospital Miguel Bombarda), in Lisbon, by order of D. Maria, and in 1883 in Porto, the Conde de Ferreira Hospital was opened[7]. The Mental Health Law (Law no. 2118/63, of 3 April), appeared for the first time in the 1960s, known at the time as Lei Sena, given its creator, having been revised on July 24, 1998 (Law no. 36/98). It allowed citizens to restrict their freedom with a view to their treatment, based on three elements of action, namely: protecting oneself, protecting third parties and protecting people and property[8].

Currently and according to the DSM-V, mental disorder is characterized by a syndrome with clinically significant impairment in cognition, emotional regulation or behavior, reflecting dysfunctionality in the psychological, biological or developmental processes underlying mental functioning. This disturbance causes significant losses in personal, occupational or social life[9].

Coupled with the history of mental illness, where patients were considered crazy and treated inhumanly, without resorting to psychopharmacology, the social perspective even nowadays is associated with myths and stigma. For Fazenda in 2008, stigma is a social role that is assigned by society in certain circumstances that break with the norms of identity. This author also designates stigma as the set of myths formed around the image of mental illness, being immediately assigned the label of "mentally ill", which results in exclusion[10].

The phenomenon of stigma in mental illness is, for patients, a source of suffering, representing a barrier to the realization of personal projects and full social integration, reflected in the loss of opportunities, self-esteem, self-concept, social support, empowerment and quality of life[11].

The patient's experience of stigma can be perceived as a combination of factors such as shame, secrecy, guilt, the "black sheep of the family" role, isolation, social exclusion, stereotypes and discrimination that, combined, represent the entire process and adaptive response taken by the subject[12].

A factor that also has an impact on the path of people with mental illness is self-stigma, which can be equally striking, occurring when the patient himself internalizes prejudice and discrimination against himself[13], something that can be harmful in the daily routine, affecting their self-esteem and self-concept[11].

Another concept inherent to stereotypes and stigmas regarding mental illness is the myth, from the Greek *mythos*, that is defined as a story that a given community or culture considers important, and can be the basis of a narrative, whether it be real or imaginary[14]. Freud and Jung are authors who have done work on this concept. For Freud, myths are perceived as the symbolic expression of the feelings and unconscious attitudes of a given population. In turn, Jung points out the universality of the myth, that is, the ability to be recognized by everyone[15].

Some of the main myths associated with mental illness were characterized as: (a) the myth of incurability, which, given the evolution of psychotropic drugs, is already attenuated; (b) the myth of disability, which most contributes to the marginalization and exclusion of people with mental disorders, being based on the ideas that patients are unable to work, take responsibility or make decisions; (c) the myth of loss of rights, with those described by the author as the most common, the right to vote, to marry and to found a family, to adopt and to manage assets, defined as the most serious from the point of view of discrimination; and (d) the myth of danger, associated with the need to control the aggressiveness of people with mental illness, a myth that is widespread in public opinion, mainly due to the diffusion in the media[16].

Thus, it can be concluded that an alleged ignorance of mental illnesses and the way to deal with patients can generate a negative stereotype. However, over the last few decades, pharmacological evolution has made it possible to normalize the daily life of these subjects, however, not avoiding the social exclusion generated by the stigmas associated with the image of the mentally ill. It is up to professionals in this area to demystify and eliminate the gaps that cause a departure or excuse for social interaction by the mentally ill.

With this is mind, the objectives of the present investigation were: to evaluate the reliability and validity of the Myths in Mental Illness Scale (MMIS) and to evaluate the existing myths in a Portuguese sample associated with mental illness, with four hypotheses being raised: men have more myths related to mental illness than women (H1), people who work with the mentally ill have fewer associated myths than those who do not work with this population (H2), people with mental illness have more myths than people without mental illness (H3) and family members of people with mental illness have fewer associated myths than people who have no family members with mental illness (H4).

METHOD

This is a quantitative, methodological, cross-sectional and descriptive study.

This was carried out with the approval of the Ethics and Deontology Committee for Scientific Research of the Lusófona University of Humanities and Technologies, having followed all the procedures of the Declaration of Helsinki. All ethical procedures for anonymity and data confidentiality were guaranteed, and informed consent was obtained.

The sample consisted of 395 participants, of both sexes, 76.4% (n=301) being female, aged between 19 and 81 years-old (M=36.96 years-old; SD=10.68).

The non-probabilistic convenience method was used, respecting the following inclusion criteria: (1) age over 18 years-old; (2) having access to the questionnaire through the online platform; and (3) understanding of the Portuguese language suitable for completing the assessment protocol. A participant was excluded for being 17 years-old, thus not fulfilling the inclusion criterion, leaving the final sample with 394 participants.

Instruments

A sociodemographic questionnaire and a Myths in Mental Illness Scale (MMIS) were constructed, considering all those found in the literature.

Sociodemographic questionnaire

This questionnaire was made up of open and closed questions, related to sociodemographic data of the participants (e.g., gender, age, place of birth, nationality, religion, marital status, relatives, district of residence, education, profession and work area).

Scale of myths in mental illness

The scale was developed by the authors with inputs from specialists in the field of mental health, based on the myths found in the scientific literature, such as those described by Fazenda: of incurability, loss of rights, incapacity, danger and others previously described[16]. In this sense, the scale consists of 36 questions, grouped into seven subscales: (1) Crime; (2) Aggressiveness; (3) Imprisonment; (4) Fear and Danger; (5) Origin and Effect; (6) Opinions; and (7) Myths.

Thus, in addition to the perception of the general myths associated with mental illness, we sought to analyze the participants' perception of the myths inherent to people with mental illness who commit crimes, the questionnaire consisting of 36 questions, with Likert-type answers of 5 points (DC – Completely disagree; DP – Partially disagree; NCND – Do not agree or disagree; CP – Partially agree; CT – Totally agree).

Procedure

For data collection, self-response instruments were used, via online, consisting of a sociodemographic questionnaire and MMIS, developed by the authors. The collection period extended over three months. Anonymity was guaranteed, the participants were informed that participation was voluntary and that they could withdraw at any time without prejudice, and it was clarified that the results would be used only for research purposes.

Statistical analysis

Statistical analyzes were performed using the Statistical Package for Social Sciences (SPSS – version 22, IBM Corp., Armonk, NY).

To characterize the sample, absolute frequencies were calculated and the means (M) and standard deviations (SD) of the variables were defined.

To assess the psychometric properties of the MMIS, an exploratory factor analysis was performed on the correlation matrix, with extraction of the factors by the principal component method, followed by a Varimax rotation. The reliability of the results of the instrument was assessed by analyzing the internal consistency by calculating Cronbach's alpha[17-19]. The means between groups were subsequently compared, using the t-*Student* test of independent samples, namely in the variables sex, work area, having a mental illness, family member with mental illness. Values of $p<0.05$ were considered as significance level.

RESULTS

Regarding their hometown, we found that most participants are from the district of Lisbon 31.5% (n=124), followed by the district of Leiria with 12.2% (n=48), and Porto with 7,6% (n=30).

As for the professional occupation of the participants, 12.7% (n=50) are policemen, 8.6% (n=34) are nurses, 7.9% (n=31) are psychologists and 45.4 % (n=179) perform other professions. It should be noted that 12.4% (n = 49) of the professionals' deal with mental health. When asked if the participants suffered from any mental illness, 94.4% (n=372) reported not suffering from any diagnosed mental illness, and 17.8% (n=70) reported having a family member who suffered from mental illness. Of those who suffer from mental illness, 2.3% (n=9) claimed to have depression and 2% (n=8) anxiety disorder.

Regarding people with mental illness who commit illegal acts, 19% (n=75) reported knowing someone in these circumstances, being the crime most reported by them, theft with 4.3% (n=17), followed by homicide with 3.8% (n=15).

When asked if they had addictive behaviors, 20.8% (n=82) replied affirmatively, and 32.5% (n=128) said they had someone in the family with this behavior.

With regard to MMIS, the main components were analyzed, followed by Varimax rotation, and throughout the analysis it was found that, of the 36 items, some had factor weights distributed by several factors, reaching a solution of 20 items that were grouped into 7 subscales, whose designation occurred according to the area of interest that the issues that comprise them cover, being thus characterized by the researchers as: (1) Crime; (2) Aggressiveness; (3) Incarceration; (4) Fear and Danger; (5) Origin and Effect; (6) Opinions; and (7) Myths, with saturation values between 0.600 and 0.916, as shown in Table 1.

The exploratory factor analysis (KMO=0.812; Bartlett $\chi 2$ sphericity test [630] 4068.138; $p<0.001$) presented 7 factors, which accounted for 66% of the explained variance of the construct.

The reliability of the results of the instrument was assessed by analyzing the internal consistency by calculating the Cronbach's Alpha, and was 0.84.

Table 1 – Factor Analysis - Matrix of rotating component.

Item	Component						
	1	2	3	4	5	6	7
DM_29	0.816						
DM_30	0.751						
DM_31	0.715						
DM_28	0.703						
DM_12		0.799					
DM_13		0.796					
DM_1		0.705					
DM_23		0.600					
DM_33			0.916				
DM_34			0.899				
DM_26				0.792			
DM_32				0.698			
DM_27				0.674			
DM_4					0.734		
DM_2					0.726		
DM_6					0.624		
DM_35						0.809	
DM_36						0.739	
DM_7							0.836
DM_10							0.657
Own numbers (Eigenvalue)	5.201	1.798	1.571	1.457	1.140	1.035	1.003
Explained variance (%)	26.004	8.988	7.857	7.283	5.698	5.174	4.088
Coefficient α^*	0.78	0.78	0.91	0.67	0.52	0.60	0.43

Source: Authors. Subtitle: * Cronbach's alpha.

The averages of the total value of the Questionnaire on the Myths in Mental Illness were compared between different groups, considering four variables: *sex*, *profession (i.e., area of work)*, *if one suffer from mental illness and if one have a relative with mental illness*, *and to assess this difference between groups*, the t-*Student* test of independent samples was performed.

As for the variable "sex", statistically significant differences were found, with men having more myths compared to women (t=-2.004; p=0.047).

In the variable "profession", statistically significant differences were found. It was verified that professionals working in the mental health area have fewer myths than other professionals (t=-3.591; p<0.001) (see Table 2).

Table 2 – Comparison of means between groups.

	n	*M*	*DP*	*t*	*p*
Sex					
Male	93	2.0903	0.51837	-2.004	0.047
Female	301	1.9671	0.51799		
Work area					
Mental health	49	1.7439	0.40021	-3.591	<0.001
Other disease	332	2.0265	0.52873		
Has mental illness					
Yes	22	2.0250	0.38937	0.267	0.790
No	372	1.9945	0.52714		
Mentally ill relative					
Yes	70	1.8543	0.52590	-2.555	0.12
No	322	2.0307	0.51331		

Subtitle: *n* – sample; *M* – mean; *DP* – standart deviation; *t* – varience; *p* – significance.
Source: Authors.

No statistically significant differences were found in the other variables.

The results of the relative frequencies obtained in the answers corresponding to the questions included in the 7 subscales, obtained after factor analysis, are described in Table 3.

Table 3 – Relative frequencies of subscales.

	DC	DP	NCND	CP	CT
Subscale 1 – Crime					
29 – Sexual harassment is more frequent in people with mental illness.	40.4%	18.8%	23.1%	16.8%	1%
30 – Thefts or robberies are more frequent in people with mental illness	56.1%	16.8%	20.6%	5.8%	0.8%
31 – Pedophilia is more common in people with mental illness.	39.3%	14.7%	18.0%	17.8%	10.2%
28 – Homicide is more frequent in people with mental illness.	31.7%	15%	25.1%	23.6%	4.6%
Subscale 2 – Aggressiveness					
12 – Are the mentally ill more aggressive in an argument?	16.8%	26.1%	22.8%	31.5%	2.8%
13 – Can mentally ill inflict more pain in aggressions?	29.4%	16.8%	29.4%	22.6%	1.8%
1 – Are people with mental illness more violent and dangerous?	16.5%	27.2%	18.3%	36.3%	1.8%
23 – People with mental illness are more dangerous than people without mental illness.	38.6%	24.1%	15.2%	20.6%	1.5%
Subscale 3 – Incarceration					
33 – The mentally ill should live away from society.	81.5%	11.9%	3.6%	3%	0%
34 – People with schizophrenia should live away from society.	81.2%	12.9%	3.8%	2%	0%
Subscale 4 – Fear and Danger					
26 – I am afraid of people with schizophrenia.	41.6%	17.5%	15.7%	23.4%	1.8%
32 – Schizophrenia is a dangerous disease.	14%	22.3%	16.5%	39.3%	7.9%
27 – I am afraid of people with depression	71.8%	14%	8.4%	5.6%	0.3%
Subscale 5 – Origin and Effect					
4 – Is mental illness related to low intelligence?	85.8%	7.9%	3%	3%	0.3%
2 – Mental illness is related to poverty.	81.5%	8.6%	5.1%	4.3%	0.5%
6 – Is mental illness contagious?	93.7%	3.3%	1.3%	1.8%	0%
Subscale 6 – Opinions					
35 – People with depression are dangerous.	75.4%	10.7%	8.1%	5.3%	0.5%
36 – People with mental illness are never competent at work	63.5%	24.1%	8.6%	3.8%	0%
Subscale 7 – Myths					
7– Is mental illness incurable?	27.9%	37.1%	13.7%	17.5%	3.8%
10 – Shouldn't the mentally ill have children?	34.3%	25.9%	17.5%	17.8%	4.6%

Source: Authors.

Regarding the subscale 1, "Criminality", 28.2% (n=111) of the participants agreed partially (23.6%) or totally (4.6%) with the statement that homicide is more common in people with mental illness. Moreover, 28% (n=110) of the participants agree that pedophilia is more common in people with mental illness, and concerning sexual harassment, 17.8% (n=70) agreed in part or totally that people with mental illness do often. Finally, and in the opposite direction, when it was stated that thefts or robberies are more perpetuated by people with mental illness, 72.9% (n=288) do not agree.

DISCUSSION

The analysis of the instrument's reliability has a good internal consistency since it is greater than 0.70, suggesting that the results are reliable[18-19]. In this study, the KMO values and the sphericity test are good and reveal the model's adequacy to the data[18-19].

Although there is a lot of research regarding mental health, myths and stigma, given the high prevalence[20] and the tendency to increase the number of diagnoses of people with mental illness due to the awareness of professionals[21], it appears that much remains to be done. This was one of the reasons why this line of research was developed, aiming to analyze the perceptions and existing myths of a Portuguese sample in relation to individuals with mental.

We proposed as working hypotheses that men had more myths than women, that those who do not work in the mental health field had more associated myths than those who work in the area, that people with mental illness have more myths than who do not suffer from mental illness, and that the relatives of people with mental illness had fewer myths than those who do not have people with mental illness in the family.

Regarding the gender variable (Hypothesis 1), it was found in the present study that men have more myths of mental illness than women, which is corroborated by two pre-existing studies[22-24]. This fact, according to the literature, may be related to the tendency towards a greater predisposition of women to help people with mental illness, namely by giving them advice and emotional support[22], being immediately possible to exemplify with the answer to the question 6, who states that *mental illness is contagious*, and to question 35, which states that *people with depression are dangerous*, in which the results obtained show a significant difference between the average among these groups.

In turn, in the variable "profession" (Hypothesis 2), significant differences were also found between those who work in the mental health area and those who do not work, concluding that those who do not work in the mental health area have more myths. These results corroborate those found in another study[25] that concluded that both education and contact with mental illness have a positive impact in reducing mental illness myths. Some examples of this difference between groups are found in question 10, which asks whether the mentally ill should not have children, and in question 26, which highlights the fear of patients suffering from schizophrenia.

As for the variable suffering from mental illness, it was found that there are no statistically significant differences between groups, that is, between those who have mental illness and those who do not (Hypothesis 3), and it would be expected that those who suffer from mental illness had more myths, since these patients usually have high levels of internalized stigma as well as deficits in terms of empowerment[26-27]. These results can be explained in view of the small number of people with mental illness.

Regarding the study hypothesis that includes family members with mental illness or not (Hypothesis 4), the results obtained did not show statistically significant differences. However, the literature tells us that those who have family members with mental illness have fewer myths, a fact which can be explained by the need for family members to get involved in the patient's daily life with a view to a balance in the patient's routine, leading them to develop interaction patterns adapted to the anxiety levels, roles and functions of family members with the context in which they live cause[28].

It was also possible to verify that when the participants were asked if the mentally ill are more violent and dangerous, 36.3% of the participants answered that they "partially agree", which corroborates a study[29] that points to the subsistence of myths based on beliefs about the danger and incurability of the mentally ill.

When asked if they were afraid of people with schizophrenia, 23.4% of the participants answered "I agree in part," as well as 28.9% answered "I agree in part" in relation to the mentally ill to bother them, data corroborated by a study[30], which states that people prefer social distance from people who suffer from schizophrenia, as it invokes a feeling of danger.

Practical implications for future research

For future investigations, we suggest to explore this line of research, improving the MMIS, and deepening emerging myths, that may be related to new technologies and growing social networks.

On the other hand, the question of the internalization of stigma from people with mental illness (self-stigma) seems to be quite pertinent. Also, it is important to assess how discrimination is perceived by the individual[25,31], as well as analyze the speed between entities when patients return who comply with safety measures in their household.

Study limitations

Regarding the limitations of this study, we pointed out the discrepancy in the sample at the gender level (301 female participants). Thus, the analyzes carried out on this variable are not conclusive, being necessary, in the future, to have a more homogeneous sample. Three dimensions of the scale have reliability lower than 0.60, which reveals low reliability of these measures.

CONCLUSION

EMDM has good psychometric properties and can be used in the Portuguese population. Our study emphasizes that men and people who do not deal with mental illness in their profession have more myths associated with it, although these results should be explored with further investigations using EMDM/MMIS.

Taking into account the global impact, and the increase in the diagnosis of mental illness, a reduction in the stigma and myths associated with mental illness becomes evident, with pertinent actions to sensitize the population that aim in reducing the myths, decreasing, as a consequence, the associated stigma. Thus, a paradigm shift is necessary for the promotion of society's mental health and early support for those who live in the scourge of these disorders.

Multidisciplinary and networking between clinical and forensic psychologists, psychiatrists, specialist nurses in mental health, and other professionals working in mental health contexts, is fundamental in fighting the stigma and demystifying the myths associated with mental illness. Thus, the development of the Myths in Mental Illness Scale is a contribution to the diagnostic assessment and subsequent analysis and implementation of actions for this purpose.

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