

Stigmatization: Devaluation and Discrimination of People Suffering from Mental Illnesses in Different Cultures

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Abstract

Stigmatization of people with mental diseases is widespread in our society, despite awareness of its negative consequences. The goal of this study was to look into the stigma toward people with mental illnesses among university students in Kyrgyzstan and Slovakia. We distributed a survey online to students to explore prejudice in many facets of life. It was clear from the results, that there is a spread tendency to stigmatize and discriminate against people with mental illness in Kyrgyzstan compared to Slovakia. People with mental illness are considered dangerous and aggressive, increasing social distance. The role of religious, supernatural, and magical approaches to mental illness is predominating.

Keywords: Stigmatization. Prejudice. Mental illness. Awareness. Negative consequences. Marginalized.

Introduction

In our society living with a mental illness or seeking help, from a professional, for our emotional distress leads to disapproval, shame, and discrimination. Stigmatization of mental disorders is normalized without shedding light on its negative impacts. People start labeling a person ‘psychotic’, ‘mentally retarded’, ‘dumb’ or many other name callings begin. Stigma is defined by the World Health Organization (WHO) as a mark of shame, disgrace, or disapproval that results in an individual being rejected, discriminated against and excluded from participating in a variety of different areas of society (World Health Organization, 2018). Stigmatization, as defined by American sociologist Goffman in 1963, is defined as being outside of society’s normal limits, being less demanded by other individuals, decreasing the individual’s respectability, and treating the individual as defective and worthless (Bilge & am, 2010; Goffman, 2014; Yüksel et al., 2015).

The WPA recommends avoiding adjective diagnoses for mental disorders because that process is the first step in stigmatization; that is, discrimination begins in the language. As a Pakistani and a Kyrgyz, we have seen people bombarding us with the Urdu word ‘لگاپ’ (pagal) and the Kyrgyz word «жинди», «акылы жок» which are translated as insane, crazy, lunatic, mad or nutty and many more. A variety of research studies have examined the beliefs of Asians about mental illness. These beliefs include that mental illness is inherent, chronic, incurable, and shameful (Fabrega, 1991), that people with mental illness are dangerous (Whaley, 1997), and that having depression is disadvantageous in society (Raguram, Weiss, Channabasavanna, & Devins, 1996).

Unbelievably, as stupid and as illiterate as it may sound, that insane person just mistakenly mentioned his/her concerns regarding their mental health issues. In the 21st century we have accepted everything, from minor to major changes, freedom of speech, choices, and much more but haven’t yet allowed the person to give importance to what is going inside the mind of those. We consider we should accept people without criticizing and labeling them. Individuals with mental illnesses are stigmatized by the society based on their sociodemographic characteristics, knowledge of the disease, and the mass media, and it is assumed

that they are dangerous, act impulsively, harm their surroundings and themselves, and have interpersonal communication problems. The truth is that society has stigmatizing attitudes toward people with mental illnesses and keeps them away from them due to their fears (am, Bilge, Engin, Baykal Akmeşe, ztürk-Turgut, & akr, 2014).

Mental illness is one of the most frequent health disorders in the United States, according to the Centers for Disease Control and Prevention (CDC). More than half of all adults in the United States will require mental health therapy at some point in their lives. Furthermore, one in every twenty-five people suffers from a serious mental condition, such as an eating disorder, bipolar disorder, PTSD, or major depression. However, besides this frequency, individuals with mental illnesses have historically been stigmatized more than those with other physical diseases (Al-Naggar, 2013; Yüksel et al., 2015). The long-term effects of many psychiatric diseases, such as schizophrenia, bipolar disorder, and alcohol and drug addiction, are the reason for the stigmatization of psychiatric diseases (Bilge & am, 2010). People suffering from mental illnesses have long been stigmatized. It is well known that doctors, nurses, teachers, and other societal leaders are more likely to label people with mental illnesses (Ebrahimi et al., 2017; Yüksel et al., 2015).

According to a national survey, 11.2 percent of all U.S. adults report routinely having worry, nervousness, or anxiety, while 4.7 percent report commonly experiencing melancholy or depression symptoms. On the contrary, surprisingly, according to the American Psychiatric Association (APA), more than half of people who have a mental illness don’t reach out for help. They delay or avoid seeking out treatment merely because of being judged or treated differently. They would prefer to live in a nightmare and suffer alone with worsening conditions because of the prejudice and pathetic society’s pre-assumptions. Moreover, in 2014 a study in India discovered that 90 percent of patients suffering from mental illnesses reported being stigmatized, regardless of age, gender, or mental illness diagnosis (Ahuja et al., 2007; Pawar, Peters, & Rethod, 2014). The attitudes and behaviors of health care workers who interact with these patients regularly are influenced by their beliefs and thoughts (Bilge & am, 2010).

Y. M. Lai, CPH Hong, and CYI Chee conducted a clinical study on the stigma of mental illness (2001). It was aimed at the baggage or burden of stigma that psychiatric patients carry. They had 300 psychiatric out-patients and day-patients, along with 100 mental health workers who were concerned about stigma. They also included a control group of 50 cardiac outpatients. Stigmatization hurt patients with schizophrenia or depression, regarding their self-esteem, relationships, and job opportunities. The majority (77% of patients with schizophrenia and 88% of patients with depression) agreed that there was a need to raise public awareness of the mental illness. Additionally, the stigma associated with the mental health profession was also evident. Around 60% of mental health workers reported that others had laughed at their line of work and about 30% had been discouraged by family members from joining the mental health profession. Also, 51% of psychiatric nurses and 15% of psychiatrists indicated that they would make a different choice if they could. The cardiac patients, on the other hand, reported very little stigmatization. It was concluded that the diagnosis of mental illness may make a person at risk of or exposed to stigmatization.

Literature Review

Stigmas about mental illness seem to be widely endorsed by the general public in the Western world (Patrick W. Corrigan, Amy C. Watson, 2002). A high level of stigmatizing attitudes has been found in Slovak research studies, where the majority of respondents considered people with schizophrenia or other mental health problems to be uncontrollable, dangerous, and potentially violent (Ocisková et al., 2015; Poluchová and Heretik, 2009). However, research on attitudes toward people with mental health problems is quite sparse in Slovakia. (Zuzana Škodová, Ivana Polčová., 2019)

Bruce Link later refined Scheff's concept by separating the numerous phases involved in taking on the persona of a mentally sick individual. The first step in diagnosing the mentally ill would be to look at cultural norms and standards, as well as the effects of deviating from them: sufferers increasingly avoid social situations to prevent conflict, which lowers their involvement in society and daily life. This social withdrawal and isolation lower self-esteem, which in turn makes people more susceptible to psychosocial stress. As a result, the social networks of those with mental illness are typically quite limited and narrow.

In 2004, an article on the Stigma of Mental Illness was published, which investigated patients' expectations and stigmatization experiences (Matthias C. Angermeyer et al.). Its goal was to find out how much stigma patients with schizophrenia or depression anticipate and experience. Furthermore, how the type of mental disorder and the social environment influence this. They interviewed 210 patients with schizophrenia or depressive episode, half of whom lived in a city and the other in a small town. The findings revealed that the majority of patients anticipate negative reactions from the environment, particularly in terms of access to work. The most frequently reported concrete stigmatization experiences were in the domain of interpersonal interaction. Even though both schizophrenia and depression patients expected stigmatization, the former reported concrete stigmatization experiences more frequently than the latter. Patients in a small town, on the other hand, expected stigmatization more frequently than patients in a city, even

though both had experienced stigmatization at a similar rate.

Selim El-Badri and Graham Mellsop studied stigma and how it affects the quality of life of people suffering from mental disorders (2007). Its goal was to assess the extent to which people with mental illnesses face stigma and discrimination in New Zealand. They also wanted to investigate their level of satisfaction with their quality of life. Patients receiving care from a variety of community mental health services were invited to take part in a survey. Questionnaires on stigma, discrimination, and quality of life were completed by 53 females and 47 males. Demographic and diagnostic data were also collected. The majority of participants reported being subjected to stigma and discrimination in a variety of settings. In addition, they had expressed dissatisfaction with their overall quality of life. It was concluded that stigma and dissatisfaction with the quality of life are common among people with mental illnesses.

Christoph Lauber and Wulf Rössler published an article (2007) that aimed to summarize results from developing Asian countries published between 1996 and 2006. For their investigation, they used Medline while focusing on English-speaking literature. The findings revealed that, when compared to Western countries, there is a widespread tendency in Asia to stigmatize and discriminate against mentally ill individuals. People with mental illnesses are perceived as threatening and violent, which increases social distance. The supernatural, religious, and magical approaches to the psychiatric condition are dominating. The path to care is frequently shaped by skepticism about mental health services and treatments. Stigmatization from family members is prevalent. Furthermore, social disapproval and devaluation of families with mentally ill members is a major concern. Psychic symptoms are perceived as socially disadvantageous and as a consequence, somatization of psychiatric disorders is common in Asia. The most pertinent concern in Asian mental health care is a lack of personal and financial resources. As a result, most mental health professionals work in cities. This, furthermore, increases barriers to seeking help and contributes to the stigmatization of the mentally ill. Mental health professionals' attitudes toward people with mental illnesses are also frequently stigmatizing.

Another study was published in 2011 by N Daumerie et al. The INDIGO study (INternational Study of DIscrimination and stiGma Outcomes) aimed to assess the impact of schizophrenia diagnosis on privacy, social, and professional life in terms of discrimination. Erroneous negative stereotypes lead to high social distance in the general population, and even among health and social professionals, affecting various aspects of daily life such as employment, housing, compliance, self-esteem, and so on. People suffering from schizophrenia, for example, have lower social participation, while public images of mental illness and social reactions add a dimension of suffering that has been described as a „second illness“. The INDIGO study aimed to collect detailed international data on how stigma and discrimination affect the lives of people with a schizophrenia diagnosis. At each participating site, they conducted qualitative and quantitative interviews with 25 people diagnosed with schizophrenia.

They also aimed to collect data from all participating countries on the laws, policies, and regulations that make a clear distinction between people with a mental illness and others, to create an international profile of such discrimination. They created a new scale (Discrimination and Stigma Scale (DISC)

and used it in person. Interviewers asked service users how far their mental illness had affected key areas of their lives, such as work, marriage and partnerships, housing, leisure, and so on. Staff at each national site gathered the best available data on whether special legal, policy, or administrative arrangements are made for people with a mental illness for country-level information. These items included information on insurance, financial services, jury service, travel visas, and others. The findings show that 46 percent of participants are not respected because of contacts with services, 88 percent are rejected by people who know their diagnosis, and 76 percent conceal their diagnosis. Positive discrimination was infrequent. Two-thirds of participants expected discrimination in career opportunities and close personal relationships, even if they'd never experienced discrimination.

Stigmatizing attitudes and discriminatory behavior toward people with severe mental illnesses are widespread in all countries. Little is known about effective anti-stigma interventions. It is undeniable that the negative effects of stigma can be formidable impediments to active recovery. Does the question arise what can be a causing factor? For once, stigma can be a result of a lack of understanding of mental disorders which leads people to be ignorant. On the other hand, it can also exist because some people have negative attitudes or beliefs towards it which leads to discrimination against these people. Additionally, the media is also playing a part in reinforcing stigma by portraying people with mental disorders in a distorted way. The media is giving rise to inaccurate stereotypes about people with mental illness. They are exaggerating situations through unwarranted references to mental illness and using hostile language toward them. To decrease the stigma and hatred towards people with these disorders we need to spread awareness and knowledge among our community. Research shows people with mental illness are more likely to be victims than perpetrators of violence.

P. W. Corrigan and A. C. Watson (2002) published an article that shed light on understanding the impact of stigma on people who suffered from mental disorders. There they, additionally, mentioned strategies for reducing public stigma. They identified three approaches for change strategies for public stigma and grouped them accordingly; protest, education, and contact. To challenge the stigmas some groups represent; others should protest against inaccurate and hostile representations of mental illness. These efforts communicate two messages. We should tell the media to stop reporting inaccurate depictions of mental illness, and we should tell the public to stop believing negative stereotypes about mental illness. Anecdotal evidence suggests that protest campaigns were successful in removing stigmatizing images of mental illness.

The protest strategy aims to reduce negative attitudes toward mental illness, but it falls short of promoting more positive attitudes that are supported by facts. Education provides information to the public so that they can make more informed decisions about mental illness. Investigators have thoroughly examined this approach to change the stigma. According to one study, people who have a better understanding of mental illness are less inclined to endorse stigma and discrimination. As a result, strategic dissemination of information about mental disorders appears to reduce negative stereotypes. Several studies have found that participation in mental illness education programs improved attitudes toward people with these challenges. These educational programs are beneficial to a diverse range of participants, including youths, adolescents, community

members, and also persons with mental illnesses.

Stigma is further reduced when members of the general public meet people with mental illnesses who can work or live in the community as good neighbors. According to research, there is an inverse relationship between having contact with a person suffering from a mental illness and endorsing psychiatric stigma. As a result, opportunities for the general public to interact with people suffering from severe mental illnesses may reduce stigma. Interpersonal contact is enhanced further when the general public can interact with people with mental illnesses regularly as peers. This is just a small piece from that article and to add further knowledge and our contribution to society, where numerous people suffer from mental illness, we should be educated on this topic and expand our knowledge. We should be active members supporting marginalized groups, whether they are mentally or physically challenging individuals, people from different races, refugees or immigrants, and others.

Kyrgyzstan and Slovakian Validation of QSAS

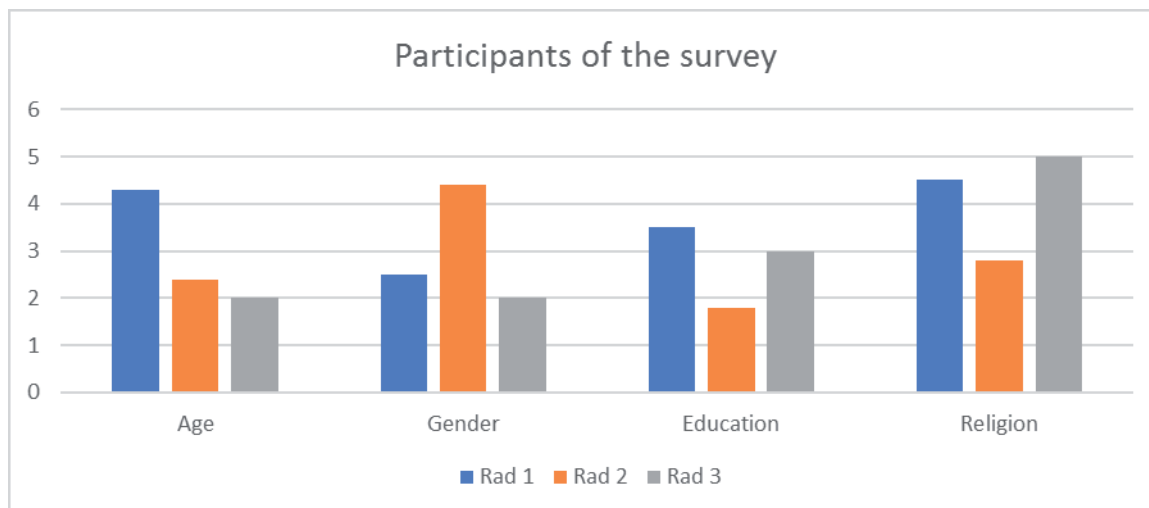
The research started before my departure to Slovakia (September - February in Kyrgyzstan) at International Ala-Too University. After winning the grant from Slovak Agency, it continued during the researcher's stay (National Slovakian Program scholarship holder, April – November 2021-2022) at Catholic University in Ruzomberok. The validation of the Questionnaire on Students' Attitudes towards Stigmatization (QSAS) was investigated in the Kyrgyz and Slovakian contexts.

Materials and method

Participants

The response rate was high at 85%. The survey questionnaire was administered via flyers posted on campus, email, and the Internet whats app, telegram, and newsgroups, and no identifiable information was collected from the participants. The students completing the questionnaire did so voluntarily. The students were informed about the aim and nature of the research. Additionally, they were assured that their answers would be anonymous. Data analysis collection took place from September 2021 to February 2022 in Kyrgyzstan and from April to June 2022 in Slovakia. Conditions of anonymity and confidentiality were monitored throughout the study. The participants included university students between 18 and 25 years old from Ala-Too International University, Bishkek, Kyrgyzstan, and Catholic University, Ruzomberok, Slovakia. All participants were from different departments, including psychology, pedagogy, medicine, management, international relations, and the English language. Additionally, they were further divided by their course of study (1st, 2nd, 3rd, 4th, 5th).

The validation of the questions on students' attitudes towards stigmatization in the Kyrgyz context included the participation of 50 students from the Ala-Too International University of Bishkek (Kyrgyzstan). The sample consisted of 21 men and 29 women. In the case of Slovakia, 29 students from the Catholic University in Ruzomberok participated: 9 of them were men and 20 were women. The selection sample followed a non-probable incidental sampling. The students were only excluded from the sample if they refused to give their informed consent to participate. The student-participants received no incentive to take part in the research.



Procedure

The questionnaire was translated into Kyrgyz, Russian and Slovak, following the back-translation method guidelines and the cultural adaptation guidelines for the tests recommended by (24). The application procedure described in the article was used in both Slovak, Kyrgyz, and Russian.

Data Analysis

The objectives of the study were to obtain information to measure cross-cultural differences and basic knowledge about stigmatization and to evaluate Kyrgyzstani and Slovakian students form attitudes towards people with mental disorders. Comparisons between Kyrgyzstan and Slovakian students revealed the expected cross-cultural differences in their beliefs toward mental illness and treatment preference

Methods: Questionnaires that collected basic demographic information, BMI (Beliefs towards Mental Illness) scale is used to assess the attitudes and is delivered to all the students.

Results: Completed questionnaires were collected from 50 subjects. In general, the participants' attitude towards people with mental illness was poor. In this study, the majority of the participants were aged 18 to 25 years compared with other age groups and were found to be females. 100% of the respondents say that they get afraid of what others would think if they were diagnosed as having a psychological mental disorder.

Findings

The research findings revealed that there was a big tendency to choose neutral answers in the stigmatized attitudes assessment covered in the questionnaire. The results were to be interpreted as giving socially acceptable answers, or they might be a cause of information lack result about this issue. Lack of information or mental health literacy is defined as the ability to know specific diseases and look for information on risk factors, mental health, or the professional assistance available. Good knowledge of mental health literacy among students has a good impact on help-seeking identification behavior in case of mental disorders. The study shows that the educational programs aimed at improving the mental health knowledge of young people had a great impact on decreasing the wrong attitudes towards mentally sick people. There is a widespread tendency to stigmatize and discriminate

against people with mental illness in Kyrgyzstan compared to Slovakia. People with mental illness are considered dangerous and aggressive, increasing social distance. The role of supernatural, religious, and magical approaches to mental illness is prevailing. The pathway to care is often shaped by skepticism towards mental health services and the treatments offered. Stigma experienced by family members is pervasive. Moreover, social disapproval and devaluation of families with mentally ill individuals are important concerns. This holds, particularly about marriage, marital separation, and divorce. Psychic symptoms, unlike somatic symptoms, are construed as socially disadvantageous. Thus, the somatization of psychiatric disorders is widespread in Kyrgyzstan. The most urgent problem of mental health care in Kyrgyzstan is the lack of personal and financial resources. The mental health professionals are mostly located in the cities like Osh, Jalal-Abad, and Bishkek. It increases the barriers to seeking help and contributes to the stigmatization of mentally ill people. The attitude of mental health professionals towards people with mental illness is often stigmatizing.

Conclusion

The results of the study demonstrate a relatively big prevalence of negative attitudes toward the professional efficacy of mental health professionals and effective treatment possibilities of disorders among high educational institution students. Our findings show that it would be better to prevent such attitudes to mental disorders, supporting the work spreading knowledge aimed at young people. Mental health literacy educational programs should be aimed at promoting positive influence on decreasing bad attitudes toward mentally sick people and improving the help-seeking behavior of students.

Culture-related considerations should be kept in mind not only in understanding the nature of stigma but also in appreciating the role of context in reducing stigmatization.

This article revealed that the stigmatization of people with mental illness is widespread in Kyrgyzstan and Slovakia. The features of stigmatization-beliefs about causes of and attitudes towards mental illness, and consequences for help-seeking-have more commonalities than differences in Slovakia. Stigmatization of psychiatric conditions continues to be a serious widespread issue. The students of the two countries are mostly aware of this

issue, but still, the stigma around mental illness persists. Even while we no longer punish the mentally ill with imprisonment, burning, or death, as was the case during the Middle Ages or in Nazi Germany, our social norms and attitudes are nevertheless unworthy of contemporary welfare states. Prejudice against those who are mentally ill still exists. Though it can be decreased through awareness, education, stigma-reducing interventions, and through spreading knowledge among adolescents, adults, and our community as a whole.

Personal contact with people with mental illness may help to improve their condition. Younger people in secondary schools should be the target-prioritized group for mental health education. Apart from the delivery of mental health knowledge, strategies to increase social contact with people having a mental illness could be considered in the design and implementation of anti-stigma programs for schools.

Literature

1. Angermeyer, M. C., Beck, M., Dietrich, S., & Holzinger, A. (2004). The stigma of mental illness: patients' anticipations and experiences. *International Journal of Social Psychiatry*, 50(2), 153-162. <https://doi.org/10.1177/00207640040043115>
2. Ay, P., Save, D., & Fidanoglu, O. (2006). Does stigma concerning mental disorders differ through medical education? *Social Psychiatry and Psychiatric Epidemiology*, 41(1), 63-67. <https://doi.org/10.1007/s00127-005-0994-y>
3. Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1(1), 16.
4. Daumerie, N., Giordana, J. Y., Caria, A., & Roelandt, J. L. (2011). Discrimination is perceived by people with a diagnosis of schizophrenic disorders. An international study of Discrimination and Stigma Outcomes (INDIGO): French results. *L'encephale*, 38(3), 224-231. <https://doi.org/10.1016/j.encep.2011.06.007>
5. El-Badri, S., & Mellsop, G. (2007). Stigma and quality of life as experienced by people with mental illness. *Australasian Psychiatry*, 15(3), 195-200. <https://doi.org/10.1080/10398560701320089>
6. Jackowska E. Stigma and discrimination against people with schizophrenia - a review of research and psychological mechanisms [Stigma and discrimination towards people with schizophrenia - a survey of studies and psychological mechanisms]. *Psychiatrist Pol.* 2009 Nov-Dec; 43 (6): 655-70. Polish. PMID: 20209878.
7. Lai, Y. M., Hong, C. P. H., & Chee, C. Y. (2001). The stigma of mental illness. *Singapore medical journal*, 42(3), 111-114.
8. Lauber, C., & Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International review of psychiatry*, 19(2), 157-178. <https://doi.org/10.1080/09540260701278903>
9. Rössler, W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO reports* 17(9), 1250-1253. <https://doi.org/10.15252/embr.201643041>
10. Sartorius N, Gaebel W, Cleveland HR, Stuart H, Akiyama T, Arboleda-Flórez J, Baumann AE, Gureje O, Jorge MR, Kastrup M, Suzuki Y, Tasman A. WPA guidance on how to combat stigmatization of psychiatry and psychiatrists. *World Psychiatry*. 2010 Oct;9(3):131-44. PMID: 20975855; PMCID: PMC2948719. <https://doi.org/10.1002/j.2051-5545.2010.tb00296.x>

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