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Cultural Stigmas Surrounding Mental Illness Impacting of Migration and Displacement

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Abstract: ***Cultural stigmas surrounding mental illness can profoundly affect individuals who migrate, influencing their mental health and access to care in several ways. These stigmas, which are deeply rooted in cultural beliefs, can lead to shame, discrimination, and reluctance to seek help, especially in new and unfamiliar environments. Cultural stigmas can result in discrimination both within the migrant community and in the host society. This can manifest as exclusion from social activities, employment, or housing, which can exacerbate mental health problems. Stigma is strongly influenced by cultural and contextual value systems that differ over time and across contexts. Mental illness stigma is a common occurrence amongst people with mental illness and caregivers (CGs) can be a potential victim of stigma themselves, there is a need to examine caregivers' perspective on the phenomenon. Stigma impacts persons live with mental illness, their families and caregivers and healthcare professionals imparting mental health care. Some cultures have an inbuilt stigma against mental health issues and this can make it difficult for a person to seek and get help.***

Keywords: Cultural stigmas, migrant community, Mental Illness (MI), mental health care, medical treatment, Stigma impacts persons

1. Introduction

Nowadays, stigma toward individuals with Mental Illness (MI) is a severe social problem as well as a heavy burden for affected people. Mental health issues refer to a wide range of mental health conditions that affect mood, thinking, and behavior. These can include disorders such as depression, anxiety, schizophrenia, eating disorders, and addictive behaviors. Mental health issues can significantly impact daily living, relationships, and physical health. These impacts manifest in several ways, influencing both the experiences of individuals who migrate or are displaced and the broader dynamics of their communities. In cultures, there may be a limited understanding of mental health issues, with symptoms often being misunderstood or dismissed. Some cultures rely heavily on traditional or spiritual healers for treating mental health issues rather than seeking professional medical help. While these practices can provide comfort, they may not address the underlying mental health conditions, delaying or preventing effective treatment.

2. Literature Review

Thomas E. Joiner Jr (2017) Research has demonstrated that military service members are at elevated risk for a range of psychiatric problems, and mental health services use is a conduit to symptom reduction and remission. Nonetheless, there is a notable underutilization of mental health services in this population. Studies identified common barriers to care (e.g., concerns regarding stigma, career impact) and facilitators to care (e.g., positive attitudes toward treatment, family/friend support, military leadership support) among this population. Critical areas for future research on treatment engagement among this high-risk population are discussed.

Simon Wessely (2015) Across military studies, one of the most frequently reported barriers to help-seeking for mental health problems is concerns about stigma. It is, however, less clear how stigma influences mental health service utilization. This review will synthesize existing research on stigma, focusing on those in the military with mental health problems. We propose that these findings may be related to intention-behavior gaps or methodological issues in the measurement of stigma. Positive associations may be influenced by modified labeling theory.

Lawrence T Lam (2014) This study aims to investigate the association between mental health literacy and the mental health status, particularly depression, among adolescents. The results have important implications, both clinically and on a population level, on the prevention of mental health problems and for the improvement of the mental health status of adolescents. Mental health literacy was measured by the Australian National Mental Health Literacy and Stigma Youth Survey with the depression vignette only. Depression was assessed by the Depression sub-scale of the Depression, Anxiety, Stress Scale.

Lavanya Narasiah (2011) Recognizing and appropriately treating mental health problems among new immigrants and refugees in primary care poses a challenge because of differences in language and culture and because of specific stressors associated with migration and resettlement. Systematic inquiry into patients' migration trajectory and subsequent follow-up on culturally appropriate indicators of social, vocational and family functioning over time will allow clinicians to recognize problems in adaptation and undertake mental health promotion, disease prevention or treatment interventions in a timely way.

Patrick W. Corrigan (2010) Public stigma robs people with mental illnesses from rightful opportunities related to work and other important life goals. Advocates have developed anti-stigma programs meant to address the prejudice and discrimination associated with these conditions. Evidence is now needed to make sense of program impact; this paper looks at measurement issues related to stigma change.

Community-based participatory research is central to this research and includes the involvement of a diverse collection of stakeholders in all phases of evaluation. These issues are summarized as ten recommendations for evaluation of anti-stigma programs.

Importance of Seeking Help

Early intervention and treatment are crucial for managing mental health issues. Untreated mental health conditions can lead to serious consequences, including relationship problems, physical health issues, and even suicide. Seeking professional help is vital for improving quality of life and overall well-being. If you or someone you know is struggling with mental health issues, it's important to reach out to a healthcare provider or a mental health professional for support.

Pre-Migration Experiences

Reluctance to Seek Help: In many cultures, mental illness is stigmatized, leading individuals to avoid seeking help even when they are suffering. This reluctance can result in untreated mental health issues that persist or worsen during migration.

Social Isolation: Stigma can lead to social isolation within one's own community, making it more difficult for individuals to find support networks before and during migration. This isolation can increase vulnerability and reduce resilience in the face of the challenges of migration.

During Migration

Stress and Trauma: The migration process, especially under conditions of forced displacement, is often highly stressful and traumatic. If mental illness is stigmatized, individuals may be less likely to seek mental health support during this time, exacerbating their distress.

Access to Services: Migrants and displaced persons may face barriers to accessing mental health services in their new location due to cultural stigmas. These barriers can include a lack of culturally sensitive services, language barriers, and fear of discrimination.

Community Dynamics: In some cases, stigma within migrant communities can prevent individuals from speaking openly about their mental health needs. This can lead to underreporting of mental health issues and a lack of adequate services tailored to these needs.

Global Perspectives

Cultural Variations in Stigma: The nature and intensity of stigma can vary greatly across cultures, influencing how mental illness is understood and addressed in different migrant and displaced populations. Understanding these variations is key to developing effective interventions.

Impact of Globalization: As migration and displacement continue to rise globally, the intersection of different cultural attitudes towards mental illness creates both challenges and opportunities. Globalization can help spread awareness and reduce stigma, but it can also lead to clashes between different cultural perspectives on mental health.

Western Culture

Approach to Mental Health: In many Western countries, particularly in the U.S. and Europe, mental health is viewed through a biomedical lens. There is a strong emphasis on diagnosis, treatment through psychotherapy, and the use of medications such as antidepressants and anxiolytics.

Stigma: Despite increased awareness, mental health issues can still carry a stigma, although it has decreased over time with efforts to normalize mental health discussions.

Treatment Methods: Cognitive Behavioral Therapy (CBT), psychotherapy, and psychiatric medication are commonly used. There is also a growing trend towards holistic approaches, including mindfulness and wellness practices.

Support Systems: Western cultures often rely on professional support (therapists, counselors) and formal support groups. Family involvement in mental health care can vary, but individual autonomy is often prioritized.

Eastern (Asian) Cultures

Approach to Mental Health: In many Asian cultures, mental health is often seen through the lens of balance, harmony, and holistic well-being. Mental health is sometimes viewed in connection with physical health, spiritual well-being, and social harmony.

Stigma: Mental health issues often carry a significant stigma. People may avoid seeking help to protect the family's reputation or to avoid shame. There can be a tendency to downplay or deny mental health problems.

Treatment Methods: Traditional practices, such as meditation, acupuncture, and herbal remedies, are often used alongside or instead of Western methods. There is growing acceptance of psychotherapy, but it is still less common than in the West.

Support Systems: Family plays a crucial role, often being the primary support system. There may be reluctance to involve outsiders, including mental health professionals, in personal issues.

Indigenous Cultures

Approach to Mental Health: Mental health is often understood in the context of community, spirituality, and connection to the land. Well-being is seen as a collective experience rather than an individual one.

Stigma: The concept of mental illness as understood in Western medicine may not exist in the same way. Instead, there may be spiritual or social explanations for what Western medicine might label as mental health issues.

Treatment Methods: Healing practices often involve rituals, spiritual ceremonies, and guidance from community elders or healers. The use of traditional medicine is common.

Support Systems: Community and family are integral to mental health care. The individual is rarely isolated in their struggles, and healing is often a communal effort.

African Cultures

Approach to Mental Health: Mental health is often seen as interconnected with spiritual and social well-being. There may be beliefs that mental illness is caused by spiritual forces, such as witchcraft or ancestral displeasure.

Stigma: Stigma is significant, and mental illness may be seen as a curse or as bringing shame to the family.

Treatment Methods: Traditional healing methods, including rituals, herbal medicine, and consultation with spiritual healers, are commonly used. Western medicine is increasingly available but may be less trusted in rural areas.

Support Systems: The extended family and community are the primary sources of support. Professional help is less commonly sought, especially in rural areas.

3. Objectives

- To the process of adapting to a new culture can be stressful, particularly when the host society has different attitudes toward mental health.
- To understand the strategies used by the people with mental illness as a way to cope with stigma and discrimination, and actualize their rights.
- To explore stigma, discrimination and rights as experienced by people living with mental illness in different settings like family, community and health care settings
- To study the underlying social processes that either strengthens or nullifies stigma, discrimination and the rights actualization of people with mental illness
- To individuals with positive attitudes preferred less social distance and this relationship was found to be statistically significant.

4. Research Methodology

Design and distribute surveys to collect data on migrants' attitudes towards mental illness, their experiences with mental health issues, and how these factors influenced their migration decisions. Conduct in-depth interviews or focus groups with migrants from different cultural backgrounds to explore their experiences and perceptions of mental illness. Migrants from such cultures may fear being judged by their community or family members, leading to isolation. This method allows for a detailed understanding of how cultural stigmas influence their migration decisions. Statistical analysis can reveal patterns and correlations. Compare migration patterns and attitudes toward mental illness across different cultural or ethnic groups. This can involve analyzing existing migration data alongside cultural indicators of stigma. Analyze media, social media, or public health records to quantify the representation of mental illness and stigma in both origin and destination countries, and how this impacts migration. Combine qualitative and quantitative methods to provide a more comprehensive understanding. Data analysis must be done systematically so as to effectively answer the research questions. For instance, you could start with qualitative interviews to identify key themes and then develop a survey to measure the prevalence of these themes in a larger migrant population. Involve migrants and communities directly in the research process to better understand their perspectives on mental illness and stigma.

5. Data Analysis

Stigma Internalization

These stigmas often stem from deeply ingrained beliefs, prejudices, or misconceptions within both the sending and receiving countries. Checking the linearity of relationship between each of the independent variables and dependent variable is an essential prerequisite for conducting a regression analysis. In the case of demographic variables, two separate correlation methods were used keeping in mind the nature of the variables.

Table 1: Demographic Characteristic of the Sample (*Patients With Mental Illness*)

Demographic Characteristics		Frequency	Percentage
Age (in years)	18-24	79	39.50%
	24-34	69	34.50%
	34-60	52	26%
Gender	Female	84	42%
	Male	116	58%
Residential Background	Urban	110	55%
	Rural	90	45%
Education Level	High School and Below	125	62.50%
	Intermediate	36	18%
	Graduation/Diploma/ B.Ed	39	19.50%
Marital Status	Married	120	60%
	Unmarried	80	40%
Socio- Economic Status	Upper Lower	50	25%
	Lower Middle	100	50%
	Upper Middle	40	20%
	Upper	10	5%

Family Type	Joint	58	29%
	Nuclear	142	71%
Duration of the Illness (in months)	6-12 Months	25	12.50%
	12-14 Months	50	25%
	24-36 Months	125	62.50%
Severity of the Illness	Severe	178	89%
	Moderate	22	11%
Diagnosis of the Illness	Psychosis	100	50%
	Bipolar Affective Disorder	18	9%
	Borderline Personality Disorder	30	15%
	Major Depressive Disorder	45	22.50%
	Substance Abuse Disorder	7	3.50%

Note. N=200

Table 1 shows the demographic details of the sample. The sample included patients within the age range of 18-60 years. There were 79 (39.5%) participants from the age group of 18-24 years, 69 (34.5%) from 24-34 years and 52 (26%) participants from the age group of 34-60 years. 84 (42%) female and 116 (58%) male participants took part in the study. 110 (55%) participants were from an urban background and 90 (45%) participants were from a rural background. The educational background of the participants ranged from high school and below 125 (62.5%) to graduation 39 (19.5%) whereas 36 (18%) participants had completed their intermediate. Among the total sample 120 (60%) participants were married, and 80 (40%) were unmarried. As far as socio Economic status (SES) is concerned, 50 (25%) participants were from the upper lower SES, 100 (50%) participants were of lower middle SES, 40 (20%) participants were of the upper middle SES and 10 (5%) participants belonged to the upper SES. 58 (29%) participants belonged to joint families while the remaining 142 (71%) belonged to nuclear families. Demographics from patients also included the clinical details of the participants such as duration, severity and diagnosis of the illness. Duration of the illness was recorded in months where 25 (12.5%) participants' illness duration was 6-12 months, 50 (25%) participants' illness duration was 12-24 months, and 125 (62.5%) participants' illness duration was 24-36 months. 178 (89%) participants reported their illness as severe and 22 (11%) participants reported it as moderate. There were 100 participants in the sample who received the diagnosis of psychosis (50%), 18 received the diagnosis of bipolar affective disorder (9%), 30 were diagnosed with borderline personality disorder (15%) 45 participants had major depressive disorder (22.5%) and 7 participants received a formal diagnosis of substance abuse disorder (3.5%).

Table 2: Social Support of Internalized Stigma and Correlation its Dimensions

	Correlation Coefficient (r)					
Variables	Internalized Stigma	Alienation	Stereotype Endorsement	Discrimination Experience	Social Withdrawal	Stigma Resistance
Social Support	-.54**	-.55**	-.40**	-.32**	-.50**	.13
Family	-.38**	-.36**	-.24*	-.21	-.33**	-.04
Friends	-.28*	-.35**	-.38**	-.19	-.32**	.26*
Significant Others	-.51**	-.46**	-.40**	-.31*	-.44**	.01

*Note. N=200; *p<.05, **p<.01*

Table 2 the he correlation scores of social support with internalized stigma and its dimensions which suggest that social support (r=-.54, p<.01) and its dimensions: family (r=-.38, p<.01), friends (r=-.28, p<.01) and significant others (r=-.51, p<.01) are significantly negatively correlated with internalized stigma. Discrimination experience subscale was found to be negatively correlated with social support and each of its dimensions but only significantly correlated with social support (r=-.32, p<.01) and significant others subscale (r=-.31, p<.05). Neither of the variables was found to be significantly correlated with stigma resistance except for friend subscale of social support scale which showed a significant positive correlation (r=.26*, p<.05).

Table 3: Correlation of Demographic Variables with Internalized Stigma and its Dimensions

	Correlation Coefficient (r)					
Variables	Internalized Stigma	Alienation	Stereotype Endorsement	Discrimination Experience	Social Withdrawal	Stigma Resistance
Gender	.18	.21	.12	.17	.23	-.21
Marital Status	.21	.28*	-.01	.18	.16	-.01
Residential Background	.08	-.02	.14	.06	.11	-.03
Family Type	.13	.24	.18	.07	.00	-.11

*Note. N=200; *p<.05, **p<.01*

Table 3 shows the correlation coefficient score of the demographic variables with internalized stigma and its dimensions. According to the results none of the variables that is, gender, marital status, residential background and family type were found to be significantly correlated with internalized stigma and its dimensions except for marital status which was significantly positively correlated with

alienation dimension (r=.28, p<.05) of the internalized stigma scale.

Table 4: Correlation Variables with Internalized Stigma and its Dimensions

Variables	Correlation Coefficient (rho)					
	Internalized Stigma	Alienation	Stereotype Endorsement	Discrimination Experience	Social Withdrawal	Stigma Resistance
Age	-.61**	-.45**	-.35**	-.43**	-.45**	.12
Education Level	-.02	.02	-.15	-.17	-.05	.16
Socio-Economic Status (SES)	-.08	-.10	-.01	-.08	-.02	-.03
Duration of the Illness	.55**	.44**	.48**	.50**	.37**	-.14
Severity of the Illness	-.17	-.03	.05	-.15	-.03	-.21

Note. N=200; **p<.01

Table 4 presents the correlation results of age, education level, SES, duration of the illness and severity of the illness with internalized stigma and its dimensions. The scores indicates that age of the participant is negatively correlated with internalized stigma (r=-.61, p<.01) and each of its dimensions: alienation (r=-.45, p<.01), stereotype endorsement (r=-.35, p<.01), discrimination experience (r=-.43, p<.01) and social withdrawal (r=-.45, p<.01) except for stigma resistance subscale. Apart from that duration of the illness was also significantly correlated with internalized stigma (r=.55, p<.01) but positively. Illness duration also showed a significant positive correlation with alienation subscale (r=-.44, p<.01), stereotype endorsement subscale (r=-.48, p<.01), discrimination experience subscale (r=-.51, p<.01) and social withdrawal subscale (r=-.37, p<.01), but not with stigma resistance subscale of internalized stigma.

6. Conclusion

The research studies have shown that, most of the time migration is a vulnerable factor to develop Mental Health complications. Cultural stigmas and mental illness deeply impact the experiences of migrants and displaced persons, influencing their mental health before, during, and after migration. Addressing these stigmas requires a multifaceted approach that includes culturally sensitive services, community engagement, and advocacy for legal protections. By tackling stigma, we can improve the mental health and overall well-being of migrant and displaced populations. The participants having limited or little knowledge of mental health held more negative attitude towards mental illness and people with mental illness. Diagnostic labels however, had no impact on the participant's desirability of social distance from patients with mental illness. Making the services inclusive, culture specific and culture free, providing necessary training for the personnel, making use of culture brokers and trained interpreters should happen in all the levels. Age, marital status and educational background of the participants significantly predicted their attitudes. Those who had good social support especially from family members and friends experienced lesser stigma. Mental health literacy was found to have no influence on people's preference for social distance from people with mental illness.

References

[1] Lavanya Narasiah, "Common mental health problems in immigrants and refugees: general approach in primary care", CMAJ, ISSNno:1488-2329, Vol. 183(12),2011, Pages.E959-E967. doi: 10.1503/cmaj.090292

[2] Thomas E. Joiner Jr, "A systematic review of help-seeking and mental health service utilization among military service members", Clinical Psychology Review, ISSNno:0272-7358, Vol.53,2017, Pages.59-78.https: //doi.org/10. 1016/j.cpr.2017.01.008

[3] Patrick W. Corrigan, "Measuring the impact of programs that challenge the public stigma of mental illness", Clinical Psychology Review,ISSN no: 0272-7358,Vol.30,Issue.8,2010, Pages.907-922.https://doi.org/10.10 16/j.cpr.201 0.06.004

[4] Simon Wessely, "Stigma as a barrier to seeking health care among military personnel with mental health problems", Epidemiol Rev., ISSNno: 1478-6729, Vol.37, 2015, Pages.144-62. doi:10.1093/epirev/mxu012.

[5] Lissa Knudsen, "The stigma of mental illness: Explanatory models and methods for change",Applied and Preventive Psychology,ISSNno:0962-1849, Vol.11,Issue.3,2015,Pages.179-190.https://doi.org/10.1016/j.appsy.2005.07.001

[6] Karine Laforest, "Working with interpreters in health care: A systematic review and meta-ethnography of qualitative studies", Patient Education and Counseling, ISSNno:1873-5134, Vol.48,Issue.2-3,2013,Pages.335-342.https://doi.org/ 10.1016/S0920-9964(00)00145-6

[7] Anthony F Jorm, "Recognition of mental disorders and beliefs about treatment and outcome: findings from an Australian national survey of mental health literacy and stigma", Aust N Z J Psychiatry, ISSNno:1440-1614, Vol.45(11), 2011, Pages.947-56. doi:10.3109/00048674.2011.621060

[8] Nicola J Reavley, "Stigmatising attitudes towards people with mental disorders: changes in Australia over 8 years",Psychiatry Res.,ISSNno:1872-7123,Vol.197(3),2012,Pages.302-6. doi:10.1016/j.psychres.2012.01.011

[9] M C Angermeyer, "State of the art of population-based attitude research on mental health: a systematic review", Epidemiol Psychiatr Sci., ISSNno: 2045-7979, Vol.26(3), 2017, Pages. 252-264.doi:10.1017/S2045796 0160006 27.

[10] Lawrence T Lam, "Mental health literacy and mental health status in adolescents: a population-based survey", Child and Adolescent Psychiatry and Mental Health, ISSN no:1753-2000,Vol.8,2014,https://doi .org/1 0.1186/1753-2000-8-26