OPINION

REDUCING STIGMA TOWARDS PEOPLE WITH MENTAL ILLNESS IN MALAYSIA

Lim Sheri

**Penang Medical College, 4 Jalan Sepoy Lines
10450 George Town, Penang, Malaysia.**

Abstract

Objective: **Mental illness accounts for 12% of the global burden of disease with a reported 1 in 5 Malaysians suffering from a psychological disorder. Sufferers have been long plagued by stigma, which results in social isolation, low-self-esteem, lower opportunities for employment, housing, and ability to achieve life goals. This essay aims to suggest strategies to overcome such stigma in the local setting.** *Methods:* **Literature search was conducted through PubMed (http://www.ncbi.nlm.nih.gov/pubmed) and Google Scholar (http://scholar.google.com.my). Data obtained was compiled as an opinion piece.** *Results:* **The factors contributing to stigma in Malaysia include a lack of public knowledge, language and cultural influences, inaccurate media portrayal, doctors' attitudes towards the field of psychiatry, and psychiatrists themselves. Stigma can be tackled in four areas: society, media, medical education, and the field of psychiatry. Firstly, psychiatric terminology can be adapted to local languages and cultural beliefs in order to avoid misconceptions. Secondly, public education is more effective if focused to targeted key groups. The media is crucial in influencing the public mind-set, and needs to be creatively engaged. Thirdly, more positive medical practitioner attitudes to mental illness can be moulded through early psychiatric postings during medical school. Finally, psychiatrists play a role in correcting misconceptions, avoiding misdiagnosis and ineffective treatments. Cultural competency leads to better management of patients by awareness towards socio-cultural and religious influences.** *Conclusion:* **A multifaceted, united coalition of effort is needed in order to tackle stigma in different contexts, and will require concerted leadership from different parties.** *ASEAN Journal of Psychiatry, Vol. 16 (2): July – December 2015: XX XX.*

Introduction

With the rapid rise in technological development, mental health has become a major issue in both developing and developed countries. According to the World Health Organization, there were at least 450 million people in the world suffer from mental illness, with 25 million of them affected by schizophrenia and 150 million by depression [1]. Historically, devastating punishments were inflicted upon those who suffered from mental illness because they were perceived to be manifestations of sinful natures [2]. Since then, the process of stigmatization has continued through the years, despite being manifest in different ways. Bryne has defined stigma as a sign of discredit or disgrace which distances a person from others [3].Society often underestimates the consequences of stigma, not realizing that it actually affects patients' awareness of the disorder and their willingness to seek for professional help [4]. It causes delays in seeking early diagnoses and treatment in early stages, affecting the willingness to be hospitalized, to adhere to recommended therapy, and to participate in rehabilitation.

The origins of stigma towards people with mental illness can often be traced to poor knowledge about what it really is and is not, as Howard Phillips once quoted, "the oldest and strongest kind of fear is the fear of the unknown". A study among the Malaysian public revealed a fear of the mentally ill, inappropriate beliefs about treatment, and the discrepancy of languages [5]. For example, the Chinese translation for schizophrenia is "精神分裂症", meaning "split personality", which leads to confusion and stigma. This raises the need to adapt the terminology of mental illness to local languages in an uncompromised standardised way. The evidence suggests that public education is more effective when messages are conveyed according to the needs of targeted key groups [6]. For instance, anti- stigma campaigns within schools are effective for the younger generation, whom research has demonstrated to have stigmatising attitudes towards mental illness at an early age [7]. Other groups such as postpartum mothers, workplaces or welfare services, will require different approaches which are tailored according to their needs. Similarly, the content of the intervention should comprise of psycho-education modules, a stigma-discrimination paradigms and specific information according to the needs [3].

Wilson et al [8] found that 46% of children's television programs in the United States used disparaging terms in reference to mental illness. This suggests that children actually learn to stereotype and stigmatize at an early age due to the influences of media. Byrne (1996), describes the extent to which the public is persistently exposed to stigmatizing portrayal of mental illness through the media [8]. Hence, mass media in Malaysia can be the best medium to start correcting misconceptions about mental illness. For example, health professionals could use this medium to educate about stigma and its devastating consequences with successful stories of how patients overcame their mental problems with the help of psychiatric treatment [5].

Another approach could be through key community leaders who hold authority because of their expertise in a certain area, for example, doctors. However, most of medical health care professionals apart from those in the field of psychiatry have no interest in mental illness related problems [4]. They tend to stigmatize and refuse to develop contacts and socialize with patients with mental illness. It is unlikely for medical students to be unaffected by these kinds of attitude towards mental illness. This is the reason why medical students should be targeted in order to eradicate the root of the stigmatization. As the level of undergraduate education increases, not only does the level of appropriate knowledge about a given disease increase but the individual medical student must also be trained to approach the patient in a more scientific and humanitarian manner [4]. Education alone is obviously not enough without providing psychiatric clinical placements of adequate duration in order to change attitudes and foster more professional behaviour.

Psychiatrists should be cautious with their role in causing stigmatization as well. Some negative experiences documented include failing to be an active listener, misdiagnosis, prolonged admission without therapeutic benefits and inappropriate use of medication. Smith [9] concluded that one in four psychiatrists tend to diagnose the "non-case" vignette as mentally ill, although they did show reasonable diagnostic skills. Syndrome-based diagnosis and a lack of objective investigations in psychiatry is particularly vulnerable to bias compared to other medical specialties. Admittedly, some of the ways in which psychiatrists are responsible for adding to stigma and bias may be due to the intrinsic nature of psychiatry itself, where it holds principles that are difficult for the public to appreciate. It is necessary for the individual psychiatrist to better explain and justify his approach by engaging the individual patient. Furthermore, practical stigma management has been proposed as useful whereby psychiatrists should address stigma towards patients as a separate issue. It has been suggested that psychiatrists should ask patients about their experiences of stigma, discrimination and the consequences for their social life, their working life and self-image, and should include these issues into the treatment plan [9].

Malaysian people generally hold widely diverse mental health beliefs and views of

help-seeking pathways due to multi religious and multi-ethnic make up of society. 60% of Malaysians who suffer from a psychiatric illness actually seek magico-religious therapy first before seeking formal psychiatric care [10]. This prioritization of traditional treatment approaches is understandable as these practices may resonate with local cultures and religious backgrounds compared to conventional psychiatry which has been largely developed in Western countries. Bulbulia&Laher's study [11], found that patients actually prefer treatment from someone who shared the understanding or knowledge about their culture, even when they were open to a Western form of treatment.

Since 1994, local practitioners have been combining religious and social-cultural elements with cognitive behavioural therapy with positive results [10]. While conventional psychiatry may act contrary to personal values, leading to anxiety, guilt, despair or isolation [12], religious and culturally-oriented psychotherapy is consistent with the patient's value and identities, allowing a deeper sense of understanding with therapists of similar backgrounds [11]. However, studies have suggested a negative relationship between religion and mental health, especially in the areas of prejudice, self-concept, intelligence, authoritarianism and self-actualization [13]. Perhaps what is more important for clinicians is to be aware of their own religio-cultural backgrounds so as to not compromise equitable clinical care by imposing their values, beliefs and expectations on the patient; an attribute embodied by the term "cultural competence" [14].

In conclusion, people with mental disorders in Malaysia are increasingly in need of acceptance and freedom from discrimination. One only needs to peruse the media for heart-breaking stories of people who struggle with mental disorders leading to untold distress, disability and drastic actions with tragic consequences. It is essential, therefore, to provide avenues for those who struggle, allowing them to live in harmony with themselves and their condition, while also receiving the acceptance of society and their own families. A united coalition of effort is needed in order to tackle stigma in different contexts, and leadership must come from ordinary men and women- including those suffering from mental illness and their families, community leaders, health care service providers and our national policymakers.

References

1. WHO. Investing in mental health. Department of Mental Health and Substance Dependance, Noncommunicable Diseases and Mental Health, World Health Organization (pp. 8). Geneva, 2003.

2. Videbeck SL. Psychiatric-Mental Health Nursing. Fifth Edition (pp.4). Philadephia: Lippincott Williams & Wilkins; 2011.

3. Byrne P. Stigma of mental illness and ways of diminishing it. Advances in Psychiatric Treatment. 2000;6:65-72.

4. Aker S, Aker AA, Boke O, Dundar C, Sahin AR, Peksen Y. The attitude of medical students to psychiatric patients and their disorders and the influence of psychiatric study placements in bringing about changes in attitude. Isr J Psychiatry Relat Sci. 2007;44(3)-204-212.

5. Yeap R, Low WY. Mental health knowledge, attitude and help seeking tendency: a Malaysian context. Singapore Med J. 2009;50(12):1169-1176.

6. Quinn N, Knifton L, Goldie I, Bortel VT, Dowds J, Lasalvia A, et al. Nature and impact of European anti-stigma depression programmes. 2013 Jan 24. Available from: http://heapro.oxfordjournals.org/content/early/2013/01/24/heapro.das076.full/DOI:10.1093/heapro/das076 [cited 2014 May 25].

7. Crisp AH, Gelder MG, Susannah TIX, Meltzer HI, Rowlands OJ. Stigmatisation of people with mental illness. British Journal of Psychiatry. 2000;177:4-7.

8. Byrne P. Psychiatric Stigma. British Journal of Psychiatry. 2001;178:281-284.

9. Smith MJ. Public psychiatry: a neglected professional role. Advances in Psychiatric Treatment. 2008;14:339-346.

10. Sheng NW. Psychotherapy in Malaysia: An Overview. Mental Health and Learning Disabilities Research and Practice. 2007;4(2):206-218.

11. Bulbulia T, Laher S. Exploring the role of Islam in perceptions of mental illness in a sample of Muslim psychiatrists based in Joannesburgh. South Africa Journal Psychiatry. 2013;19(2):52-54.

12. Gartner J. Religion and Mental Health in Shafranske (ed.), Religion and the Clinical Practice of Psychology, 187-214.

13. Haque A. Psychology and religion: two approaches to positive mental health. Intellectual Disclosure. 2000; 8(1):81-94.

14. Bharathy A, Malayapillay M, Russel V. Crosscultural narratives on death and beareavement among medical students: implications for undergraduate curricula. International Journal of Medical Education. 2013; 4: 68-74.

Corresponding author: *Lim Sheri, 5ᵗʰ year medical student, Penang Medical College, 4 Jalan Sepoy Lines 10450 George Town, Penang, Malaysia.*

Email: sherilim@ms.pmc.edu.my