Exploring Mental Illness Stigmatisation Among Malaysian Adults: A Review of the Literature

Abstract

Background Stigmatisation is considered a ‘second illness’ for mental illness sufferers and is highly prevalent in Malaysia. Stigmatisation negatively impacts wellbeing, recovery and productivity. Addressing stigmatisation is integral towards attaining higher quality of life. Aims To explore mental illness stigmatisation in Malaysian adults.

Methods A systematic literature review was conducted using thematic analysis to synthesise and categorise evidence. Five key themes emerged, providing insight into mental health (MH) stigmatisation.

Findings Cultural beliefs, limited knowledge of MH and lack of MH education were factors influencing stigmatisation. Stigmatisation significantly affected wellbeing and function of mental illness sufferers. Interventions such as contact-based education, effectively reduce stigmatising attitudes manifested by healthcare providers.

Conclusion Establishing MH literacy, encouraging patient contact, promoting MH awareness and strengthening MH policies could reduce mental illness stigmatisation and its impact in Malaysia. Future research is warranted to investigate the impact on physical wellbeing and anti-stigmatising strategies targeting the general public.

Keywords: mental health, mental illness, mental disorders, stigma, discrimination, prejudice, adult, Malaysia

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Conflict of interest
The authors declare no conflicts of interest.

Introduction
Mental illness affects 450 million people worldwide, leading to mental health related disability, morbidity and mortality (Tay et al., 2018). In Malaysia, mental health disorders continue to
rise, affecting 16.8% of the population according to the latest data (Midin et al., 2018). Furthermore, explorations of mental disorders amongst Malaysian adults by Midin et al. (2018) and Tay et al. (2018) revealed that the 2015 National Health and Morbidity Survey (NHMS) demonstrated a threefold increase in incidence over the period 1996-2015. The gravity of the challenge of mental health in Malaysia is illustrated by the stark observation that 3 out of 10 Malaysian adults have experienced some form of mental illness. Subsequently, the 2019 National Health and Morbidity Survey revealed that the prevalence of depression was 2.3%, accounting for half a million of Malaysian adults (NHMS, 2019).

Petkari et al. (2018) assert that individuals living with mental illness encounter a double challenge: firstly, the effects of the illness on their lives; and secondly, stigmatising attitudes by society. Additionally, people with mental illness experience a ‘second illness’ due to the social label that is attached to mental illness which requires additional coping (Mestdagh & Hansen, 2014; Morgan et al., 2018). Midin et al. (2018) suggest that mental health services in Malaysia are governed by National Mental Health policies and legislation where advocacy is emphasised. Mental health advocacy is a fundamental component in mental health policies and is a strategy that aims to reduce stigma and discrimination in people with mental health disorders (World Health Organization [WHO], 2019). Although mental health advocacy is evident in Malaysian mental health policies and legislation, mental illness stigmatisation is still prevalent. Addressing stigmatisation is integral in achieving an equitable quality of life for these individuals. Ibrahim et al. (2019) and Rao et al. (2009) suggest that stigma is a socially constructed characteristic, where people living with mental illness are considered undesirable by society, leading to their exclusion, discrimination, and devaluation. Mental illness stigmatisation contributes to low self-esteem, non-adherence in treatment, increased severity of mental illness symptoms, isolation, and suicide (Ellison et al., 2013; Maunder & White, 2019). Additionally, Clement et al. (2013) and Ellison et al. (2013) identified that the prevalence of stigmatisation leads to discrimination of those living with mental illness, especially in relation to opportunities associated with housing, employment, and resource allocation for mental health services. Rao et al. (2009) mentioned that WHO and World Psychiatric Association established the interrelation of anguish, disability, and poverty. The existence of mental illness stigmatisation can
result in the absence of help-seeking behaviours, acting as a barrier for effective treatment and rehabilitation (Rao et al., 2009; Sun et al., 2019).

Sun et al. (2019), suggest the risk factors associated with stigmatisation are influenced by the lack of mental health literacy and prior contact with people living with mental illness. Stigma is articulated through social distancing, devaluation, or avoidance of people with mental illness (Ellison et al., 2013; Petkari et al., 2018). Rao et al. (2009) identified that despite healthcare professionals being aware of the issues related to stigmatisation, stigmatising attitudes amongst healthcare professionals persist, raising concern, as mental health services are the main avenue for people living with mental illness to achieve satisfactory societal integration. Choudhry et al. (2016) identified that cultural context is a key factor in determining knowledge, awareness, and perceptions, because the interpretation of the illness varies between cultures; for example, many southeast Asians perceive that mental illness is caused by supernatural elements, and that the illness is a consequence of deities’ wrath or denial.

Morgan et al. (2018) and Sun et al. (2019) suggest mitigating the negative impact of stigmatisation. It is critical to identify those factors contributing to mental illness stigmatisation in order to develop anti-stigma interventions and policies. Furthermore, this reflects findings of Maunder & White (2019) who report that the WHO Comprehensive Mental Health Action Plan 2013-2020 specified the importance of reducing stigmatisation as it imposes a significant impact on the wellbeing of people living with mental illness in comparison to the symptoms of the illness itself. Consequently, anti-stigma strategies that are underpinned by stigma research are required (Maunder & White, 2019). Strategies pertaining to stigma prevention and reduction are more often targeted towards healthcare professionals and employers because of their frequent contact and influence with those living with mental illness (Morgan et al., 2018). However, WHO (2003) previously stated that supporting people living with mental illness involves targeting the general public through mental health promotion and mental health literacy which are crucial for success. Specifically, Wei et al. (2015) concluded that mental health literacy is a useful strategy for recognising mental illness, reducing stigmatisation, and improving help-seeking behaviours. They also propose that mental health literacy is a determining factor for improving mental illness stigmatisation at individual, public and institutional levels revealed by the evidence. Undoubtedly, it is crucial to consider cultural beliefs as part of mental health literacy and understanding those beliefs can provide the foundation for raising awareness of the impact of stigmatisation because cultural beliefs can influence help-seeking behaviours of those living with mental illness, affecting their recovery (Choudhry et al., 2016).

**Aims**

It is apparent that mental illness stigmatisation is prevalent in Malaysia due to the strong association between mental illness and stigma. The aim of this review is to explore stigmatisation of mental illness
among the adult population in Malaysia by identifying stigma influencing factors, impact of stigmatisation and strategies that can be applied to reduce stigmatisation of adults with mental illness.

**Methods**

This literature search was initially conducted during the period of February – June 2020 and updated in November 2022, using a systematic strategy following the recommendations of Booth, Sutton, and Papaioannou (2016) and Aveyard, Payne, and Preston (2016).

**Search Strategy**

To adopt a systematic search strategy, the inclusion and exclusion criteria should reflect the overall aim of the review in order to select the relevant material. In view of this, studies that explored social or public stigmatisation of mental illness were included while studies that explored aspects other than social or public stigmatisation of mental illness were excluded. A systematic search of the literature was performed using the electronic databases: PsycINFO, CINAHL, PubMed, Scopus, Science Direct, Cochrane, Medline, Web of Science to provide a comprehensive range of literature.

The search strategy used the following key words: mental health, mental illness, mental disorders, stigma, discrimination, prejudice, adult, Malaysia. These search terms were combined to develop a search string: ("mental health" OR "mental illness" OR "mental disorders") AND (stigma* OR discrim* OR prejudi*) AND adult AND Malaysia*. The inclusion criteria were adults, primary research articles, empirical studies, peer reviewed journal articles. The exclusion criteria were children, adolescents, other languages, and review articles. The search was limited to papers written in English and published between 2010 and 2022. To ensure that the relevant information was thoroughly searched and identified, additional searches examining reference list and author searches were also performed. The search string, inclusion and exclusion criteria including the limits were applied to the selected electronic databases.

**Study Selection**

The “Preferred Reporting Items for Systematic Reviews and Meta-Analyses” (PRISMA) guidelines were followed by using the four-stage flow diagram (Moher et al., 2015) (Table 1). Each article was
selected by following each stage of the PRISMA flow diagram. Table 1 illustrates the decision trail for the selection of articles. All primary studies detailing stigma and mental illness were included in the review. All selected articles were included in the review regardless of their quality rating; however, their impact was measured accordingly. The articles retrieved were screened by their titles and abstracts to assess if they met the inclusion criteria. Those articles that met the inclusion criteria were accepted for the review. Subsequently, the articles underwent a full-text assessment to assess its eligibility for inclusion. A total of 13 papers were included in the final review. The included articles were a combination of quantitative and qualitative studies which aimed to explore perceptions of people and examine effectiveness of interventions associated with mental illness stigmatisation in a defined population. Specifically, these studies investigated factors that influence stigmatisation in Malaysia, impact of stigmatisation and the efficiency of anti-stigma interventions. The studies were conducted in Malaysia, Britain, Hong Kong, and China.

Critical Appraisal

The included articles for this review were individually appraised on their methodological quality by using the Critical Appraisal Skills Programme (CASP) checklist (CASP UK).
Data Analysis

A meta-summary matrix was completed, to produce a thematic analysis of the data drawing upon the approach suggested by Aveyard et al. (2016), where “a priori themes” are predominantly based on the emerging objectives of the research generated by the search strategy. This adapted form of thematic analysis (Aveyard et al., 2016) demonstrated the presence of five key themes: stigma...
influencing factors; socio-demographic factors; stigmatising attitudes; impact, and strategies to reduce stigma.

Results
A total of 13 papers were included, comprising a mixture of ten quantitative studies (Fernandez et al., 2016; Ng et al., 2017; Minas et al., 2011; Khan et al., 2011; Loo et al., 2012; Razali & Ismail, 2014; Loo & Furnham, 2012; Loo & Furnham, 2013; Swami et al., 2010 & Li et al, 2019) and three qualitative studies (Hanafiah & Bortel, 2015; Berry et al., 2020 & Low et al., 2019). Considering the distinct dearth of literature in this subject, the recommendations of Booth et al. (2016) and Aveyard et al. (2016) were followed and included for this review. The main themes identified were stigma influencing factors, socio-demographic factors, stigmatising attitudes, impact of stigmatisation and strategies to reduce stigma.

Stigma Influencing Factors
Mental illness stigmatisation in Malaysia was influenced by cultural beliefs, limited knowledge regarding mental illness and the lack of education and awareness. Both cultural beliefs and limited knowledge could be associated with the lack of education and awareness (Berry et al., 2020; Hanafiah & Bortel, 2015; Khan et al., 2011; Loo et al., 2012).

1. Cultural Beliefs
Cultural beliefs appeared to be a considerable factor for mental illness stigmatisation as mental illness was conceptualised as spiritual and superstitious in nature. Berry et al. (2020) and Khan et al. (2011) explored the beliefs regarding mental illness in Malaysia where their study participants believed that the causes of mental illness were based on spiritual and superstitious elements. Both studies utilised semi-structured interviews and validated questionnaires respectively which added to their internal validity.

2. Limited Knowledge
Limited knowledge regarding mental illness appeared to be a contributing factor towards mental illness stigmatisation in Malaysia. Berry et al. (2020) and Loo et al. (2012) explored the knowledge of
mental illness in Malaysia where Loo et al. (2012) cross-cultural study allowed for comparison of medical illness knowledge from a cultural perspective. Participants from Malaysia acquired the lowest scores in the study compared to participants from Britain and Hong Kong. Both studies identified similar findings using different methodological approaches.

3. Lack of Education and Awareness
Lack of mental health education and awareness were considered as primary factors for mental illness stigmatisation in Malaysia. Hanafiah & Bortel (2015) explored the perspectives of mental health professionals on mental illness stigmatisation in Malaysia where their study participants recognised the lack of mental health education and awareness as primary causes for stigmatisation. Additionally, the authors approached mental illness stigma from a wider perspective to gain further understanding. However, their findings were only limited to the urban settings in Malaysia.

Socio-demographic Factors
Socio-demographic factors such as rural and urban living including educational status were highlighted as to be considerable factors contributing to mental health stigma, while working in a mental health setting had no positive influence on stigmatising attitudes manifested by healthcare providers. Rural and urban communities demonstrated differences in knowledge and beliefs regarding mental illness which influenced stigmatisation. Razali & Ismail (2014), Hanafiah & Bortel (2015), Minas et al. (2011), Loo & Furnham (2013), Loo & Furnham (2012) and Swami, Loo & Furnham (2010) investigated the effects of socio-demographic factors identifying the prevalence of stigmatising attitudes among their participants in Malaysia. Urban participants recognised and categorised mental disorders better in comparison to rural participants. Subsequently, rural participants believed spiritual and supernatural were causes for mental illness while urban participants believed that genetics and lifestyle were causes for mental illness although some urban groups believed that the causes for mental illness were supernatural. Both rural and urban participants recognised stress and pressure as causes for mental illness. A quantitative study by Swami et al. (2010) provided additionally insight pertaining to the treatment of mental illness where rural and urban participants recognised religiosity as treatment for mental illness, although the participants advocated counselling and lifestyle as better treatments. Additionally, urban living was considered a risk factor for mental illness stigmatisation as
urban settings have better health care access and resources whereby individuals are required to manage themselves without depending on societal support.

**Stigmatising Attitudes**

Stigmatising attitudes were prevalent among the general public, family members and healthcare providers towards people with mental illness. However, positive attitudes such as willingness to support and expressing compassionate views were also evident among the general public. Minas et al. (2011), Razali & Ismail (2014) and Berry et al. (2020) investigated stigmatising attitudes among their participants. Low scores in Care and Support elements and high scores in Avoidance, Social Distancing and Negative Stereotype elements were identified in Minas et al. (2011) and Razali & Ismail (2014) studies; these scores reflected negative attitudes. In contrast, Berry et al. (2020) study explored attitudes amongst its participants towards individuals living with mental illness where positive attitudes were portrayed. The finding of Minas et al. (2011) study which related to the prevalence of stigmatising attitudes amongst healthcare providers was particularly interesting.

**Impact of Stigmatisation**

Stigmatisation negatively impacted the psychological, social, and emotional wellbeing of people with mental illness. Consequently, the lack of help-seeking behaviours occurred in these individuals which led to delayed disclosure of their mental health status, thus, affecting their recovery. Additionally, the function and productivity of these individuals in the wider society were disabled. Hanafiah & Bortel (2015), Berry et al. (2020) and Low et al. (2019) explored the perceptions and views among their study participants who were living with mental illness. These individuals were negatively affected psychologically which led to reluctance in disclosing their mental health status and help-seeking behaviours due to stigmatisation, compromising their recovery. They also experienced alienation, disrespect and loneliness including unemployment due to being a liability to employers. Participants from the study of Low et al. (2019) sought societal support and respect to enhance their self-esteem.
Strategies to Reduce Stigma

Education, contact, and psychiatry training were considerable strategies that reduced stigmatising attitudes. Additionally, mental health advocacy, policies and legislations including education and awareness were fundamental strategies advocated to reduce mental health stigma. Fernandez et al. (2016), Ng et al. (2017) and Li et al. (2019) examined the effectiveness of strategies to reduce stigmatisation of mental illness among their study participants. These studies found that education and contact significantly improved stigmatising attitudes, especially the combination of both education and contact where contact was either face-to-face or video based. Razali & Ismail’s study (2014) illustrated that psychiatry training correlated with the reduction of stigmatising attitudes. The study of Hanafiah & Bortel (2015) asserted that education and awareness were recognised as significant for societal understanding and acceptance of mental illness.

Discussion

Based upon the evidence collated in this review, the stigmatisation of mental illness observed in Malaysia could possibly be explained by the influence of cultural beliefs where its population believes that the causes of mental illness are spiritual and superstitious. These beliefs, however, are not consistent across the population: people from rural settings in Malaysia recognised spiritual and superstitious as causes for mental illness, while people from the urban settings recognised biological and lifestyle as causes for the illness. However, some rural and urban communities had similar beliefs where they believed spiritual, and superstition were linked to the causation of mental illness. These findings were supported by Choudhry et al. (2016) where their study also presented varied cultural beliefs such as scientific and supernatural causes for mental illness. Different cultural beliefs between rural and urban settings in Malaysia can be attributed to Vygotsky’s socio-cultural theory, where people are inclined to agree with the culture of the communities they belonged to, shaping their beliefs (Choudhry et al., 2016).

Mental illness stigmatisation among the Malaysian population could be explained by the influence of limited knowledge regarding mental illness. In addition, this knowledge differed from a demographic perspective where people from the urban setting had a better understanding of mental illness compared to the people from the rural setting. These findings were supported by Yeap & Low (2009).
where their study found that knowledge of mental illness in Malaysia was considerably low, particularly within the rural settings. In addition, educational attainment was found to strongly influence mental health stigmatisation. Yeap & Low (2009) study also identified that lower educational status was related to limited knowledge pertaining to mental health. In view of this, it could be considered that those with lower educational status tend to have limited knowledge of mental illness, which can then influence stigmatising attitudes.

The lack of mental health education and awareness were also identified as influencing factors for stigmatisation. Whilst there was limited evidence on the lack of mental health education and awareness associated with mental health stigmatisation in this review, these areas were not the specific focus of those studies included in the review. A study by Furnham & Swami (2018) identified that education improves mental health literacy as it addresses the knowledge and beliefs regarding mental illness; therefore reducing mental illness stigmatisation. The authors further assert that it is also important to consider urban and rural variances, culture and educational status as these factors influence mental health literacy while also informing educational interventions.

Stigmatising attitudes were not only observed amongst the general public, but also amongst healthcare providers. It was anticipated that healthcare providers would display positive attitudes. However, Rao et al. (2009) identified that stigmatising attitudes were prevalent among healthcare providers. Care delivery towards patients with mental illness was found to be reduced as a result of stigmatising attitudes manifested by healthcare providers. Displaying stigmatising attitudes can infringe ethical principles, affecting the delivery of care which can lead to poor recovery outcomes for patients (Aveyard, 2019). It is therefore imperative to improve stigmatising attitudes amid healthcare providers as to avoid these attitudes from interfering in the provision of care required for patient recovery.

The impact of stigmatisation is a significant issue in the maintenance of wellbeing, recovery, and productivity of people with mental illness, due to reduced help-seeking behaviors and delayed disclosure. Similar findings were reported by Lasalvia et al. (2013) in a study of 35 countries, including Malaysia, where 79% of participants reported stigmatisation in various aspects of life, especially
wellbeing and productivity. It was found that the impact from stigmatisation was accentuated by the manifestation of stigmatising attitudes such as avoidance and negative stereotype from the general public, family members and healthcare providers towards these individuals (Minas et al. (2011) & Razali & Ismail (2014). Reducing the impact of stigmatisation by improving stigmatising attitudes is integral to the wellbeing and recovery of people living with mental illness.

Anti-stigma interventions were shown to be effective strategies in reducing stigmatising attitudes amongst healthcare providers. These interventions involved either education or contact with individuals suffering from mental illness, although some of the interventions had a combination of both approaches. Rössler (2016) recommended these approaches, particularly contact, for stigma reduction as being the most effective approaches. A further study by Maunder & White (2019) found that interventions involving contact-based education were effective as participants were educated on the nature and impact of mental illness including its stigmatisation. This could explain the significant reduction in stigmatising attitudes observed amid study participants following contact-based education, demonstrating the effectiveness of a contact and education combination. A contact-based approach can use either video or face-to-face contact, although Maunder & White (2019) suggest that video-based contact is less effective than face-to-face contact because of the decreased personal contact. However, this review found no significant differences in terms of the effectiveness between both types of contact.

The study conducted by Petkari et al. (2018) found that patient contact appeared to be a key component in establishing positive attitudes towards mental illness and that anti-stigma interventions that excluded contact were only effective for a short-term. It was not clear whether contact-based interventions in the studies of this review were effective on a long-term period. Nevertheless, it is beneficial to consider contact as a vital component in future anti-stigma interventions being an effective long-term strategy. Additionally, policies and wider advocacy were recognised as central towards reducing mental health stigmatisation in Malaysia. While mental health policies and advocacy in Malaysia existed, they were not fully effective as reflected by the high prevalence of stigmatisation in the country. Arguably these policies lacked demographic focus or have not fully addressed the key factors that influence stigmatisation which have been shown in this review. Additionally, these policies
advocated interventions that were not the most efficacious. For these policies and the notion of advocacy to be fully effective, they must tackle mental illness stigmatisation by ensuring that cultural beliefs and limited knowledge regarding mental illness are completely addressed, ideally through face-to-face contact-based education. Limited knowledge and cultural beliefs regarding mental illness seem to be key issues in Malaysia and can be correlated with the lack of mental health education and awareness. Furthermore, it is possible that the lack of mental health education and awareness in Malaysia have some influence on mental health literacy in the country. These issues contribute to stigmatising attitudes and therefore will need to be addressed urgently in order to reduce the impact of stigmatisation which could be achieved through contact-based interventions and robust mental health policies.

Strengths and Limitations
The strengths of this review include the transparency of its methodological processes and the usage of ethical research papers. The review also adds to the outcomes of mental health research in relation to stigmatisation across Malaysia and reveals the need for healthcare providers to be more supportive and portray positive attitudes towards people living with mental illness. The limitations of this review were only including articles in the English language and excluding grey and unpublished literature.

Conclusion
Mental illness stigmatisation in Malaysia is influenced by cultural beliefs, limited knowledge regarding mental illness and the lack of mental health education and awareness which must be addressed by considering socio-demographic factors. Reduction in stigmatising attitudes can be achieved by implementing effective anti-stigma strategies such as contact-based education and robust mental health policies and advocacy. Consequently, avoiding the negative impact of stigmatisation on the lives of those suffering from mental illness. It is vital to target healthcare providers in order to promote optimal care and support which are necessary for the recovery of people living with mental illness. Additionally, reducing negative attitudes within the general public is also significant to enable societal support for individuals with mental illness towards their wellbeing and recovery. Recommendations to reduce stigmatisation in Malaysia include establishing mental health literacy, strengthening current mental health policies and advocacy, promoting mental health awareness, and encouraging patient
contact. Future research is warranted to investigate the impact of stigmatisation on physical wellbeing and interventions that reduce stigmatising attitudes among the general public.

Relevance for Clinical Practice

The findings from this review demonstrate that implementation of effective anti-stigma interventions such as contact-based education is an important anti-stigma strategy. This strategy is effective as it addresses the knowledge and beliefs related to mental illness while encouraging patient contact. Additionally, the findings from this review could also inform policymakers in strengthening mental health policies and advocacy by addressing cultural beliefs, inadequate mental health knowledge and those socio-demographic factors that influence stigma while also advocating for effective anti-stigma interventions could lead to a more targeted approach in tackling mental health stigmatisation in Malaysia.

Keywords: mental health, mental illness, mental disorders, stigma, discrimination, prejudice, adult, Malaysia

Key points

Cultural beliefs, limited knowledge of mental illness and mental health, and lack of mental health education negatively influence stigmatisation. Stigmatisation significantly affects the wellbeing and function of people living with mental illness. Interventions such as contact-based education, effectively reduce stigmatising attitudes manifested by healthcare providers. Establishing MH literacy, encouraging patient contact, promoting MH awareness and strengthening MH policies could reduce mental illness stigmatisation and its impact in Malaysia.

Reflective questions

How often do you undertake assessment of stigmatisation experienced by people living with mental health conditions in your clinical practice and what do you feel would help to develop your confidence in doing this?
Can you identify barriers and enablers that impact on the stigmatisation of patients suffering from a mental illness?

What important things can be learned from this review?

References


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