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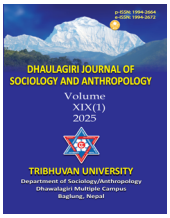

Social Stigma Towards People with Mental Illness: A Study Among Nepalese University Students

Raj Karki[1], Sunita Raut[1] and Birendra Bahadur Dahal[1]
1. Tri-Chandra Multiple Campus

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Abstract

Social stigma towards people with mental illness (PWMI) involves society's endorsement of stereotypes, prejudice, and discrimination directed at PWMI. From a sociological perspective, stigma and mental illness are not only experienced at the individual level, but they are also socially constructed phenomena shaped by cultural norms, institutional practices, and power dynamics that serve particular social functions such as maintaining social order, reinforcing norms, and managing perceived threats. This study aimed to examine the association between social stigma towards PWMI and both education/training related to mental health and contact with PWMI. A quantitative cross-sectional design was employed, and data were collected from 246 master's-level students at Tribhuvan University, Nepal, using socio-demographic questions, along with the CAMI and the RIB scales. Findings of this study revealed a statistically significant ($p < 0.01$ and Cramer's $V > 0.2$) associations between stigmatizing attitudes and both education/training and contact. Notably, direct contact was more strongly associated with positive attitudes than indirect contact. The findings also showed that students who had both education/training and contact, exhibited more positive attitudes towards PWMI than those with only one or neither. These positive attitudes stem from the roles that both education/training and contact play in challenging and reducing stereotypes. This is supported by Link and Phelan's model of the stigmatization process, which posits that stereotypes precede negative attitudes such as prejudice and discrimination. Additionally, reduction in stereotypes also diminishes the perceived need for stigma's social functions, thereby making the maintenance of mental illness stigma less necessary.

Keywords: mental illness, sociology of mental illness, social stigma, stigma towards mental illness

Introduction

Stigma generally refers to devalued stereotypes. Goffman (1986, p. 13) defined stigma as an "attribute that is deeply discrediting", emphasizing the way certain characteristics can profoundly undermine an individual's social standing. When society endorses such stereotypes, it leads to social stigma, whereas when people with discrediting attributes internalize such stereotypes, it leads to self-stigma (Corrigan et al., 2010).

From a sociological standpoint, stigma and mental illness are not only individual-level experiences but socially constructed phenomena shaped by cultural norms, institutional practices, and power dynamics, with their effects mediated and moderated by individuals' psychosocial resources, social status, and social roles

✉: sunitaraut2070@gmail.com

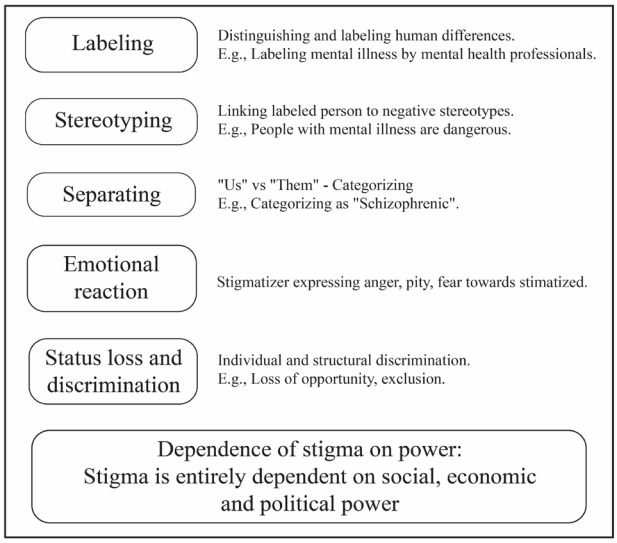
(Aneshensel et al., 2013; Link & Phelan, 2001). In line with the sociological lens, Horwitz (1999) presented four distinct sociological approaches for studying mental illness. They are etiological, sociological psychology, social response and social constructionist. The current study draws on the third approach: the social response studies, which shifts the analytical focus from individuals with mental illness to the broader societal reactions towards mental illness and its symptoms. This third approach aims to address questions like how responders' relation with people with mental illness (PWMI), ethnicity, social class, age, gender, social networks, and culture leads to variation in their reactions towards mental illness and its symptoms (Horwitz, 1982).

Theoretical Foundation: Link and Phelan's Model for Stigmatization Process

Based on the sociological studies, Link and Phelan (2001) have expanded Goffman's definition of stigma. They have defined stigma as the convergence and occurrence of labelling, stereotyping, separation, emotional reaction, status loss, and discrimination. Moreover, this entire process of stigmatization, as shown in Figure 1 is dependent on the presence of social, economic, and political power.

Figure 1

Stigmatization Process Based on Link and Phelan's Model (2001)



For example, at first, people (esp. those in power) tend to distinguish and label human differences, then the labelled individuals are linked to undesirable characteristics and negative stereotypes based on dominant cultural beliefs, which leads to some degree of "us" versus "them" mentality and lastly as a result of all this, the labelled individuals (esp. those who are powerless) faces emotional reaction like anger, pity, fear as well as status loss and discrimination, leading to unequal outcomes, such as reduced opportunities, increased social distancing and so on (Link & Phelan, 2001).

In the context of mental illness, public (or social) stigma refers to society's endorsement and enactment of stereotypes, prejudice, and discrimination against those with mental illness (Corrigan et al., 2010). This means that when a person experiences mental illness, they not only face the challenges of their condition, such as disability and distressing symptoms, but also the burden of social stigma, which often leads to further negative consequences, including discrimination, loss of opportunities, and other forms of marginalization (Corrigan et al., 2004).

The role of social, economic, and political power in the generation, impact, and perpetuation of mental illness stigma can also be observed through differences in stigmatization across gender and layers of intersectionality (Oexle & Corrigan, 2018; Robillard, 2010). For example, in South Asian societies, where patriarchy has persisted in evolving forms despite improvements in structural and indicator-based gender equality (Hapke, 2013), women with mental illness face double stigmatization compared to men. Since the patriarchal belief system privileges men over women, women with mental illness are more likely to be abandoned, abused, blamed, and frequently confronted about their mental illness (Loganathan & Murthy, 2011; Srivastava & Anand, 2020; Trani et al., 2015). One manifestation of such stigma towards women with mental illness is the accusation of witchcraft, as they are disproportionately more likely to be labelled as witches. Moreover, the symptoms of mental illness and the resulting decline in social status (Link & Phelan, 2013) make them even more vulnerable to such accusations (Adinkrah & Adhikari, 2014; Grigaitė, 2018). Studies have shown that differences in the degree and expression of stigmatization are not just limited to gender but also exist across other power-based social categories such as caste and class (Chatzitheochari & Butler-Rees, 2023). For instance, a study by Trani et al. (2015), in India, found that stigmatization linked with severe mental illness compounded with being women and/or belonging to marginalized classes or castes.

Additionally, a global survey on mental illness stigma by Seeman et al. (2016), conducted between September 23, 2013, and May 23, 2015, revealed that compared to people from developing countries, the people from developed countries were less likely to endorse the statement that said PWMI are more violent than others and they were also more likely to believe mental illness is similar to physical illness. These kinds of differences in societal attitudes further exacerbate the level of stigmatization towards PWMI in developing countries like Nepal compared to developed countries.

For instance, a study conducted in Nepalese society found derogatory words like "*mad, crazy, psycho, pagal, baulaha, taar khuskeko, jhalla, dimag navayeko, baudhik apangata, bojhu lageko, aaushi purnima lageko,*

khuskhet" (list of Nepalese derogatory words for PWMI) are commonly aimed at PWMI as well as their family members (Mental Health Innovation Network, 2013, p. 38). Similarly, in Nepalese society, mistreatment of PWMI extends beyond derogatory words and stigmatization (Luitel et al., 2015; Regmi et al., 2004); it also includes physical abuse and violations of human rights, even by their own family members (Bhandari, 2014; Gautam, 2014; Rai, 2015). Further highlighting the urgency of the issue, a cross-sectional study conducted by Jha et al. (2019) in Bhaktapur, Dhanusha, and Dolakha districts of Nepal found that the prevalence of mental disorders among adults is 13.2%, while the prevalence among children is 11.2%.

Thus, understanding and acknowledging the current status of social stigma towards PWMI is important, as it helps in developing appropriate mental health policies and treatment plans, as well as awareness programmes and policies (Corrigan et al., 2010). Informed by previous empirical studies and a model for the stigmatization process (Byrne, 2000; Corrigan et al., 2010; Link & Phelan, 2001), this study aimed to examine the association between social stigma towards PWMI and both education/training related to mental health and contact with PWMI..

Methodological Approach

This study employed a quantitative cross-sectional research design, targeting master-level students. The primary data used in this study were collected from master's level students enrolled in various courses under the Faculty of Humanities and Social Sciences at Tri-Chandra Multiple Campus and the University Campus of Tribhuvan University, with the help of paper-based survey questionnaires. In addition, secondary data were obtained from news, scholarly articles, and previous research studies.

Table 1

Department-wise student enrollment as of May 2023

Department	Total students	Sample percent
Psychology	268	29.11%
English	128	25%
Sociology	360	9.4%
Anthropology	69	20%
Rural Development	234	14.53%
Social Work	100	18%
Economics	271	13.28%
Total	1430	17.20%

Source. Respective departments, May 2023

In this study, purposive sampling was used. To be included in the study, respondents had to be enrolled in a master's level programme under the Faculty of Humanities and Social Sciences at either Tri-Chandra Multiple Campus or the University Campus of Tribhuvan University at the time of data collection. Data were collected in April and May 2023, following approval from the Sociology Department at Tri-Chandra Multiple Campus. All the respondents were over 18 years old and participated voluntarily. Out of 1430 students, data were collected from 250 students. Upon excluding four incomplete responses, the final sample size consisted of 246 respondents.

Data Collection Tools and Analysis

For data collection, a self-administered paper-based survey questionnaire was used, which contained socio-demographic questions, the 40-item CAMI scale developed by Taylor and Dear (1981), and the 8-item RIB scale developed by Evans-Lacko et al. (2011). CAMI scale has four subscales: Authoritarianism, Benevolence, Social restrictiveness and Community mental health ideology (CMHI) (Taylor & Dear, 1981). Permission to use the CAMI and RIB scales was obtained from their developers via email.

To obtain the level of overall stigma in the CAMI scale and relevant attitude level in its subscales and the RIB scale, the scores were divided into quartiles based on the highest possible score for each scale, and corresponding cutoff scores were established (Venkatesh et al., 2015). For CAMI and its subscales, score up to 1st quartile was considered low, score between 1st to 2nd quartile was considered medium and score above 2nd quartile was considered high. In the case of RIB scale, higher score means low social distancing. Thus, for RIB scale, score below 2nd quartile was considered high social distancing, score between 2nd and 3rd quartile was considered medium social distancing and score above 3rd quartile was considered low social distancing.

Similarly, three items of the CAMI scale were modified to make the language gender neutral without manipulating the original meaning (e.g., woman and man were changed into person or woman/man) (Chambers et al., 2010; Masuda et al., 2009).

The collected data were managed and analyzed using Microsoft Excel 2021 and IBM SPSS v25 software. Similarly, descriptive statistics, Cronbach's alpha test, and Chi-square test, along with its post-hoc test, were used for data analysis.

Reliability of Data

To make sure the collected data were of good quality and standard, reliability tests were done using Cronbach's alpha test.

As shown in Table 2, the internal consistency of the CAMI scale based on the collected data was found to be 0.874, whereas for the RIB scale it was 0.810, indicating good reliability. Similarly, among the subscales of the CAMI scale, the Cronbach's α values were 0.49 for Authoritarianism, 0.738 for Benevolence, 0.675 for Social restrictiveness, and 0.766 for the CMHI subscale. These results suggest that most subscales demonstrated acceptable

to good internal consistency, except for Authoritarianism.

Table 2

Results of Cronbach's α Test

Scale	*Cronbach's* α value
CAMI Scale	0.874
RIB Scale	0.810
Authoritarianism subscale	0.49
Benevolence subscale	0.738
Social restrictiveness subscale	0.675
CMHI subscale	0.766

Source. Field survey, 2023

Results

Socio-Demographics Information of Respondents

Table 3 gives brief socio-demographic information of respondents like gender, respondents' field of study, and prior contact with PWMI.

Table 3

Socio-demographic Characteristics of Respondents'

Socio-demographic characteristics	N	%
Gender		
Female	140	56.9
Male	102	41.5
Missing	4	1.6
	246	100
Educational institution		
Tri-Chandra Multiple Campus	78	31.7
University Campus, TU	168	68.3
	246	100
Subject major		
Anthropology	14	5.7
Economics	36	14.7
English	32	13
Psychology	78	31.7
Rural Development	34	13.8
Social Work	18	7.3
Sociology	34	13.8
	246	100
Contact with PWMI		
Yes	130	52.8
No	116	47.2
	246	100
Type of contact		
Direct contact	48	19.5
Indirect contact	37	15
Mixed contact	45	18.3
None	116	47.2
	246	100

Source. Field survey, 2023

Gender-wise Analysis

The association between students' gender and level of stigma was analyzed, and the results are presented in Table 4. During the gender-wise analysis, the cases with missing gender data were excluded.

Table 4

Chi-Square Test Results for Levels of Social Stigma by Respondents' Gender

Variable	Low	Medium	High	χ^2-value	*p*-value
Social stigma level					
Female	24.3%	22.9%	52.9%	1.011	0.603
Male	23.5%	28.4%	48.0%		
Social distancing level					
Female	25.7%	33.6%	40.7%	1.84	0.399
Male	29.4%	25.5%	45.1%		
Authoritarian attitude					
Female	18.6%	27.9%	53.6%	0.181	0.913
Male	18.6%	25.5%	55.9%		
Benevolent attitude					
Female	20.7%	29.3%	50.0%	1.836	0.399
Male	23.5%	21.6%	54.9%		
Social Restrictive attitude					
Female	21.4%	20.0%	58.6%	0.166	0.921
Male	19.6%	21.6%	58.8%		
CMHI attitude					
Female	18.6%	26.4%	55.0%	5.327	0.070
Male	25.5%	14.7%	59.8%		

Source. Field survey, 2023

The results in Table 4 suggest that there was no statistically significant association betweem stigma level and students' gender. Furthermore, the descriptive data showed mixed result, without any comparable pattern. However, if the percentage of respondents in the medium level category is excluded and the difference between the high and low levels percentage value is considered, a more comparable pattern emerges. The pattern suggests, male students reported comparatively higher positive attitude in overall stigma and benevolent attitude. Similarly, female students reported comparatively higher positive attitude in social distancing, authoritarian attitude, social restrictive attitude, and CMHI attitude. Thus, the overall pattern from descriptive data reveals that female students reported a slightly more positive attitude than the male students.

Difference Between Psychology and Other Subjects

The association between students' field of study (psychology and other subjects) and level of stigma was analyzed. The obtained results are presented in Table 5.

Table 5

Chi-Square Test Results for Levels of Social Stigma across Psychology and Other Subject

Variable	Low	Medium	High	χ^2 -value	Effect size
Overall social stigma level					
Psychology major	44.9%	21.8%	33.3%	28.17	0.338
Other subject	14.3%	26.8%	58.9%		
Social distancing level					
Psychology major	46.2%	28.2%	25.6%	23.86	0.311
Other subject	17.9%	31.5%	50.6%		
Authoritarian attitude					
Psychology major	32.1%	37.2%	30.8%	27.23	0.333
Other subject	12.5%	22.0%	65.5%		
Benevolent attitude					
Psychology major	11.5%	23.1%	65.4%	10.55	0.207
Other subject	27.4%	27.4%	45.2%		
Social restrictive attitude					
Psychology major	35.9%	20.5%	43.6%	17.24	0.265
Other subject	13.7%	20.2%	66.1%		
CMHI attitude					
Psychology major	12.8%	10.3%	76.9%	19.52	0.282
Other subject	26.2%	26.8%	47.0%		

Source. Field survey, 2023

Note. All results were statistically significant at $p < 0.01$

Table 6

Chi-Square Test Results for Levels of Social Stigma across With and Without Contact

Variable	Low	Medium	High	*p*-value	Effect size
Overall social stigma level					
With contact	33.1%	23.8%	43.1%	0.002	0.229
Without contact	13.8%	26.7%	59.5%		
Social distancing level					
With contact	36.9%	32.3%	30.8%	*p*<0.001	0.285
Without contact	15.5%	28.4%	56.0%		
Authoritarian attitude					
With contact	27.7%	29.2%	43.1%	*p*<0.001	0.279
Without contact	8.6%	24.1%	67.2%		
Benevolent attitude					
With contact	18.5%	20.0%	61.5%	0.004	0.211
Without contact	26.7%	32.8%	40.5%		
Social restrictive attitude					
With contact	30.8%	17.7%	51.5%	*p*<0.001	0.262
Without contact	9.5%	23.3%	67.2%		
CMHI attitude					
With contact	16.9%	20.0%	63.1%	0.061	-
Without contact	27.6%	23.3%	49.1%		

Source. Field survey, 2023

The data in Table 5 reveal that there were statistically significant ($p < 0.01$) associations between students' subject major and both the level of stigmatizing attitudes and social distancing attitude towards PWMI, with Cramer's V > 0.2. The value of effect size was highest for overall stigma, followed by authoritarian, social distancing, CMHI, social restrictive and benevolent attitude. Overall, the results indicated that enrollment in a psychology course was more strongly associated with positive attitudes towards PWMI.

Contact-wise Analysis

Association between type of contact and level of stigma was analyzed and the obtained results are tabulated in Table 6, Table 7 and Table 8.

The results of the chi-square test presented in Table 6 revealed statistically significant ($p < 0.005$, Cramer's V > 0.2) associations between students' contact with PWMI and levels of stigmatizing attitudes across all dimensions, except for CMHI attitude. Among the significant results, the highest (0.285) effect size was in social distancing attitude whereas lowest (0.211) was in benevolent attitude.

Furthermore, to probe the difference in strength of associations by type of contact with PWMI, students' self-reported types of contact were divided into four types: direct, indirect, mixed, and none (Song et al., 2005). "Direct contact" includes oneself currently suffering/suffered in the past from mental illness, one's family member currently suffering/suffered in the past from mental illness, one's close friend currently suffering/suffered in the past from mental illness, or one's job involving working with PWMI. Whereas "Indirect contact" includes someone who has volunteered/advocated for PWMI, who has a neighbour suffering from mental illness, who knows someone with mental illness but they aren't close friends, or who has seen PWMI while walking or traveling. Similarly, "Mixed contact" refers to type of contact, where student has both direct and indirect type of contact with PWMI. "None/ no contact" means student reported having neither direct nor indirect contact with PWMI. Here, for a direct contact category, students must have selected any one or more of the four statements related to direct contact type and must not have selected any statements related to indirect contact type; the reverse applied for the indirect contact category.

Table 7

Chi-Square Test Results for Levels of Social Stigma across Contact Type

Variable	Low	Medium	High	*p-value*
Overall social stigma level				
Direct contact	33.3%	22.9%	43.8%	0.001
Indirect contact	18.9%	21.6%	59.5%	
Mixed contact	44.4%	26.7%	28.9%	
None	13.8%	26.7%	59.5%	
Social distancing level				
Direct contact	41.7%	35.4%	22.9%	$p<0.001$
Indirect contact	18.9%	37.8%	43.2%	
Mixed contact	46.7%	24.4%	28.9%	
None	15.5%	28.4%	56.0%	
Authoritarian attitude				
Direct contact	25.0%	33.3%	41.7%	$p<0.001$
Indirect contact	18.9%	24.3%	56.8%	
Mixed contact	37.8%	28.9%	33.3%	
None	8.6%	24.1%	67.2%	
Benevolent attitude				
Direct contact	25.0%	16.7%	58.3%	0.007
Indirect contact	16.2%	32.4%	51.4%	
Mixed contact	13.3%	13.3%	73.3%	
None	26.7%	32.8%	40.5%	
Social Restrictive attitude				
Direct contact	33.3%	20.8%	45.8%	$p<0.001$
Indirect contact	18.9%	10.8%	70.3%	
Mixed contact	37.8%	20.0%	42.2%	
None	9.5%	23.3%	67.2%	
CMHI attitude				
Direct contact	18.8%	25.0%	56.3%	0.183
Indirect contact	18.9%	21.6%	59.5%	
Mixed contact	13.3%	13.3%	73.3%	
None	27.6%	23.3%	49.1%	

Source. Field survey, 2023

Results of association test tabulated in Table 7 reveal that all dimensions of stigmatizing attitude except for the CMHI attitude were significantly ($p<0.01$) associated with different types of contact (direct, indirect, mixed, or none).

The results of the post-hoc test in Table 8 reveal that students with mixed contact were significantly more likely to exhibit positive attitudes, whereas those with no contact were significantly more likely to display negative attitudes towards PWMI. These associations were statistically significant.

Table 8

Post-hoc Test on Levels of Social Stigma across Contact Type after Bonferroni Correction

Variable	Low*	Medium*	High*
Overall social stigma level			
Direct contact	0.091	0.684	0.275
Indirect contact	0.434	0.586	0.254
Mixed contact	$p<0.001$	0.802	0.001
None	$p<0.001$	0.604	0.010
Social distancing level			
Direct contact	0.010	0.408	0.002
Indirect contact	0.239	0.292	0.940
Mixed contact	0.001	0.330	0.038
None	$p<0.001$	0.512	$p<0.001$
Authoritarian attitude			
Direct contact	0.212	0.257	0.047
Indirect contact	0.970	0.709	0.762
Mixed contact	$p<0.001$	0.730	0.002
None	$p<0.001$	0.368	$p<0.001$
Benevolent attitude			
Direct contact	0.624	0.100	0.300
Indirect contact	0.331	0.334	0.971
Mixed contact	0.108	0.032	0.001
None	0.120	0.023	0.001
Social Restrictive attitude			
Direct contact	0.016	0.922	0.040
Indirect contact	0.768	0.119	0.129
Mixed contact	0.002	0.952	0.012
None	$p<0.001$	0.277	0.012

Source. Field survey, 2023

Note. Adjusted α-value after Bonferroni correction is 0.0042,

*p-value for respective levels of stigmatizing attitude.

Overall, results from the association tests suggest that mixed contact was more strongly associated with positive attitudes towards PWMI than indirect contact or no contact, while direct contact was more strongly associated with positive attitudes than no contact.

Interaction Between Education/Training Related to Mental Health and Contact with PWMI

To further examine whether education/training related to mental health or contact with PWMI was more strongly associated with positive attitudes towards PWMI, students were categorized into four groups based on their course of study and type of contact, which were then analyzed.

Table 9

Chi-Square Test Results for Levels of Social Stigma across a Combination of Psychology and Other Subject × Contact with PWMI

Variable	Low	Medium	High	*p-value*
Overall social stigma level				
Psychology×Contact: Yes	52.6%	17.5%	29.8%	
Psychology×Contact: No	23.8%	33.3%	42.9%	*p*<0.001
Other subject×Contact: Yes	17.8%	28.8%	53.4%	
Other subject×Contact: No	11.6%	25.3%	63.2%	
Social distancing level				
Psychology×Contact: Yes	54.4%	26.3%	19.3%	
Psychology×Contact: No	23.8%	33.3%	42.9%	*p*<0.001
Other subject×Contact: Yes	23.3%	37.0%	39.7%	
Other subject×Contact: No	13.7%	27.4%	58.9%	
Authoritarian attitude				
Psychology×Contact: Yes	36.8%	33.3%	29.8%	
Psychology×Contact: No	19.0%	47.6%	33.3%	*p*<0.001
Other subject×Contact: Yes	20.5%	26.0%	53.4%	
Other subject×Contact: No	6.3%	18.9%	74.7%	
Benevolent attitude				
Psychology×Contact: Yes	8.8%	17.5%	73.7%	
Psychology×Contact: No	19.0%	38.1%	42.9%	0.004
Other subject×Contact: Yes	26.0%	21.9%	52.1%	
Other subject×Contact: No	28.4%	31.6%	40.0%	
Social restrictive attitude				
Psychology×Contact: Yes	42.1%	19.3%	38.6%	
Psychology×Contact: No	19.0%	23.8%	57.1%	*p*<0.001
Other subject×Contact: Yes	21.9%	16.4%	61.6%	
Other subject×Contact: No	7.4%	23.2%	69.5%	
CMHI attitude				
Psychology×Contact: Yes	10.5%	10.5%	78.9%	
Psychology×Contact: No	19.0%	9.5%	71.4%	0.001
Other subject×Contact: Yes	21.9%	27.4%	50.7%	
Other subject×Contact: No	29.5%	26.3%	44.2%	

Source. Field survey, 2023

The results shown in Table 9 reveal a combination of subject × contact type had a statistically significant association with the level of stigma, with $p < 0.005$ across all dimensions of stigmatizing and social distancing attitudes. To further explore this result, subsequent post-hoc tests were done, and the data are tabulated in Table 10.

As shown in Table 10, the post-hoc test results indicate that psychology students with some level of contact with PWMI were significantly more likely to demonstrate positive attitudes towards PWMI. In contrast, students from non-psychology backgrounds without any contact with PWMI were significantly more likely to exhibit negative attitudes towards PWMI. These associations were statistically significant.

Table 10

Post-hoc Test on Levels of Social Stigma across a Combination of Psychology and Other Subject × Contact with PWMI

Variable	Low*	Medium*	High*
Overall social stigma level			
Psychology×Contact: Yes	*p*<0.001	0.129	*p*<0.001
Psychology×Contact: No	0.984	0.370	0.446
Other subject×Contact: Yes	0.141	0.403	0.595
Other subject×Contact: No	*p*<0.001	0.986	0.002
Social distancing level			
Psychology×Contact: Yes	*p*<0.001	0.435	*p*<0.001
Psychology×Contact: No	0.744	0.767	0.987
Other subject×Contact: Yes	0.415	0.150	0.542
Other subject×Contact: No	*p*<0.001	0.399	*p*<0.001
Authoritarian attitude			
Psychology×Contact: Yes	*p*<0.001	0.206	*p*<0.001
Psychology×Contact: No	0.966	0.025	0.042
Other subject×Contact: Yes	0.629	0.854	0.830
Other subject×Contact: No	*p*<0.001	0.027	*p*<0.001
Benevolent attitude			
Psychology×Contact: Yes	0.005	0.096	*p*<0.001
Psychology×Contact: No	0.703	0.187	0.400
Other subject×Contact: Yes	0.370	0.341	0.930
Other subject×Contact: No	0.070	0.115	0.004
Social restrictive attitude			
Psychology×Contact: Yes	*p*<0.001	0.826	*p*<0.001
Psychology×Contact: No	0.842	0.678	0.861
Other subject×Contact: Yes	0.766	0.325	0.576
Other subject×Contact: No	*p*<0.001	0.381	0.008
CMHI attitude			
Psychology×Contact: Yes	0.017	0.021	*p*<0.001
Psychology×Contact: No	0.737	0.161	0.149
Other subject×Contact: Yes	0.993	0.147	0.232
Other subject×Contact: No	0.024	0.149	0.002

Source. Field survey, 2023

Note. Adjusted α-value after Bonferroni correction is 0.0042

**p*-value for respective levels of stigmatizing attitude.

Overall, the results of the Chi-square test and post-hoc analysis presented in Table 5, Table 6, Table 9 and Table 10 suggest that while both mental health education/training and contact with PWMI were significantly associated with positive attitudes; studying psychology, a field that inherently includes both education and training related to mental health, was more strongly associated with positive attitudes than contact alone. Furthermore, the findings indicate that students with both mental health education/training and contact with PWMI exhibited more positive attitudes than those with only one or neither.

Discussion

The gender-wise analysis showed that the gender of students was not significantly associated with the level of social stigma. This finding aligns with similar studies conducted in different regions. For instance, studies conducted among nurses in the UK (Schafer et al., 2011), among medical students and staffs at Nigeria (Ukpong & Abasiubong, 2010) as well as among Japanese and US students at a US based university (Masuda et al., 2009) reported similar gender related findings that aligned with current study. However, these finding contrasts with studies conducted in other regions with different population samples, which have found a significant association between respondents' gender and stigmatizing attitudes. To be more specific, a study done in South India and Indonesia showed significantly higher stigma towards PWMI among female (Hartini et al., 2018; Venkatesh et al., 2015) and study done in Southern Ghana showed female endorsing higher authoritarian views than male (Barke et al., 2011). Two studies done in Czech Republic showed male possessing more stigmatizing attitudes towards PWMI (Janoušková et al., 2017; Winkler et al., 2016). Similarly, studies done in Taiwan (Song et al., 2005) and European countries (Chambers et al., 2010) showed female possessed more benevolent and CMHI attitudes.

Nevertheless, a comparative analysis of various studies reveals a pattern that indicates when the study sample consists of educated individuals, such as students or medical professionals, there is often no significant association of stigma with gender. However, when differences across gender are observed, females generally exhibit more positive attitudes than males. This current study, that involves master-level students, supports these last two notions. This tendency of females showing comparatively higher positive attitudes may be attributed to their innate disposition and socialization, which foster greater empathy than that of their male counterparts (Hoffman, 1977; Löffler & Greitemeyer, 2023), a pattern consistent with social role theory (Eagly & Wood, 2012).

The subject-wise comparisons in this study suggested students from the psychology course possessed significantly more positive attitudes towards PWMI than the students from other courses. This finding is consistent with studies done in different countries, which also showed education/training on mental health is associated with positive attitudes towards PWMI. For instance, study done in Pakistan among medical and non-medical students (Waqas et al., 2014), study done among medical students and physicians in Nigeria (Ighodaro et al., 2015), study done among nurses in USA before and after their psychiatric nursing course (Morrison, 2011), study done among mental health and non-mental health professionals and trainees in USA (Smith & Cashwell, 2010), study done among medical students and teachers in Czech Republic (Janoušková et al., 2017), study done among community people in Indonesia (Hartini et al., 2018) and study done among general population and medical doctors in Czech Republic (Winkler et al., 2016) supports this finding regarding education/training on mental health.

One possible reason for this result can also be that students who are more empathetic or who already possess knowledge of mental health are perhaps more likely to choose a helping profession like psychology (Janoušková et al., 2017; Smith & Cashwell, 2010).

Similarly, the findings of contact-wise analysis of this study suggest that students who had some form of prior contacts with PWMI were significantly more likely to report positive attitudes towards PWMI. This finding aligns with studies done in several other countries. For instance, study in Pakistan among university students (Waqas et al., 2014), study in UK (Schafer et al., 2011) and European countries (Chambers et al., 2010) among nurses, study in Brazil among medical students (da Rocha Neto et al., 2017), study in Nigeria among medical students and physicians (Ighodaro et al., 2015), study in USA among nursing students before and after clinical exposure (Morrison, 2011), study in Taiwan among general public (Song et al., 2005) and study in Indonesia among community people (Hartini et al., 2018), all observed similar findings regarding contact with PWMI.

To be more specific, students who reported having mixed (direct and indirect) contact with PWMI consistently showed lower stigmatizing and social distancing attitudes towards PWMI than the students who reported to have only direct or indirect contact. A possible explanation for students with mixed types of contact showing lower social stigma and social distancing is that multiple contacts with PWMI may be more effective and students who have multiple contacts with PWMI are perhaps more likely to have different types of contact (direct and indirect). A study done in Taiwan by Song et al. (2005) also supports this finding, which suggested direct contact with PWMI is more influential than indirect contact, proving the nature and quality of contact is more important than just a mere contact (Allport, 1954).

In the current study, the possible mechanism by which education/training and contact is associated with more positive attitudes towards PWMI appears to be their effectiveness in challenging and reducing stereotypes associated with a person labelled as mentally ill (Couture & Penn, 2003; Desforges et al., 1991; Link & Phelan, 2001; Stangor, 2016). For example, when individuals receive education or training on mental health, their previously held false stereotypes about PWMI are replaced with factual information, leading to the development of more neutral and informed perspectives. Similarly, when individuals who hold stigmatizing attitudes come into contact with PWMI, their stereotypical expectations often do not align with the reality of their experience. This mismatch prompts a need to reconcile the inconsistency between their expectations and actual experiences, which

can weaken or disrupt the stigmatization process. As a result, both education/training and contact can interrupt the stigmatization process, leading to a reduction in negative attitudes and discriminatory behaviours.

Moreover, findings from this study indicate that compared to only contact with PWMI, knowledge or training on mental health, such as enrollment in a psychology course, has more stronger association with positive attitude towards PWMI. Additionally, students who were both enrolled in a psychology course and had prior contact with PWMI demonstrated the lowest levels of stigma and the least social distancing compared to other students. However, if a similar study were conducted among the general public using brief training sessions or workshops, without the depth of a specialized psychology course, the findings might have differed. In such contexts, personal contact with PWMI may be more associated with positive attitudes towards PWMI than education/training alone.

Theoretical Linkage

According to Phelan et al. (2008), stigma serves three primary social functions: exploitation and domination (keeping people down), norm enforcement (keeping people in), and disease avoidance (keeping people away). In the context of mental illness stigma, only two functions are relevant: norm enforcement and disease avoidance. Even though these functions aren't intended to directly benefit dominant groups, these functions help to reinforce social norms and protect the perceived health and safety of the dominant social group through the mechanism of Bourdieu's symbolic violence (Guise, 2024; Link & Hatzenbuehler, 2016; Phelan et al., 2008). Thus, in the context of mental illness, the significance of these two functions can be diminished by reducing the stereotypes regarding mental illness, making the maintenance of social stigma towards PWMI less necessary in society. This is also supported by Link and Phelan's (2001) model for the stigmatization process and findings of this study, which suggests that challenging stereotypes can mitigate subsequent steps in the stigmatization process, such as separation, emotional reactions, status loss, and discrimination, reducing the stigma towards PWMI.

Limitations

The current study has some limitations. First, this study used a self-administered survey questionnaire, which may have led to response bias. Second, the respondent might have interpreted the concept of mental illness differently based on their past experience and cultural background. Third, the quantitative cross-sectional design of the study limits it from establishing cause and effect relationships in stigma reduction and prevents from exploring the subjective meaning and perspectives of respondents on mental illness and associated stigma.

Finally, future research should include more controlled comparisons between mental health education/training and contact with PWMI to better understand their relative associations with stigmatizing attitudes among the general public. Additionally, studies should also explore the underlying mechanisms of mental illness stigma within the Nepalese context..

Conclusions

According to Goffman (1986), individuals managing a stigmatized identity often adopt various strategies to cope with social judgment. This is unsurprising, given that the consequences and implications of stigmatization extend from macro to micro level (Holder et al., 2019). For instance, at the macro level, structural discrimination can result in a loss of opportunities and limitations of legal rights for PWMI (Corrigan et al., 2004). Similarly, at the micro level, as explained by modified labelling theory, individuals may withdraw from social interactions to avoid potential rejection or refrain from seeking professional help to escape formal labelling (Corrigan et al., 2010; Link & Phelan, 2013). While such strategies provide temporary relief, they often worsen the symptoms and increase the functional impairment (Holder et al., 2019). Therefore, reducing the stigma toward PWMI is essential to increase help-seeking behaviours and to ensure that individuals can access support without fear of stereotypes, prejudice, or discrimination (Corrigan et al., 2010; Masuda et al., 2009).

The findings of this study underscores the importance of combining mental health education or training with social exposure to promote positive attitudes towards PWMI (Cerully et al., 2018). Furthermore, previous studies suggest that, for social exposure to be effective, a positive and successful case example should be used, as representations of severe or extreme cases of mental illness can inadvertently reinforce negative stereotypes (Angermeyer & Matschinger, 1996).

Declarations

Ethics Approval and Consent to Participate

This research maintained the ethical consideration during survey and response taking process with participants.

Consent for Publication

Not Applicable.

Availability of Data and Materials

Data are available.

Conflict of Interests

There is no conflict of interest with any individual or Institutions.

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Raj Karki is the primary author, and Sunita Raut and Birendra Bahadur Dahal are co-authors.

Use of AI
I confirm that this paper's content is written entirely by human.

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About Authors

Raj Karki https://orcid.org/0009-0006-9886-369X is a researcher with Master's Degree in Sociology as well as Psychology. His areas of interest include research methodology, statistical analysis, and digital mental health, with a focus on the use of technology-based interventions for depression and anxiety. He is skilled in both quantitative and qualitative data analysis. He has previously served as a Data Officer in an international development organization and is the creator of two educational YouTube channels (in English and Nepali), where he shares content on psychology, research methods, and data analysis.
Email: rajkarki053@gmail.com

Sunita Raut, MPhil https://orcid.org/0000-0002-6347-628X is an Assistant Professor in the Department of Sociology at Tri-Chandra Multiple Campus, Tribhuvan University, Nepal. She is currently pursuing a PhD at Tribhuvan University. Being a results-driven sociologist, she has extensive experience in teaching, thesis supervision, and academic research. She is skilled in both qualitative and quantitative data analysis, research project implementation, and capacity building. She is also skilled in curriculum design, training delivery, and stakeholder coordination at both the local and national levels. Mrs. Raut has demonstrated expertise in supporting research coordinators through project planning, monitoring, and field visits. For her MPhil thesis in 2016, she was awarded a research grant by the University Grants Commission (UGC), Sanothimi, Bhaktapur, Nepal. She is the author of several research papers and articles published in peer-reviewed national and international journals.
Email: sunitaraut2070@gmail.com

Birendra Bahadur Dahal https://orcid.org/0009-0002-7261-0038 is an Assistant Professor in the Department of Sociology at Tri-Chandra Multiple Campus, Tribhuvan University, Nepal. He has extensive experience in teaching, thesis supervision, and research. His primary areas of interest include water resources and nutrition.
Email: birendradahal2021@gmail.com