Stigmatization of individuals suffering from mental illness and methods of counteraction – analysis of the statements of the elderly

Anna Bańbura, Małgorzata Opoczyńska-Morasiewicz

Jagiellonian University, Faculty of Philosophy, Institute of Psychology

Summary

Aim. Stigmatization of those who seem to be superficially or innately different produces many negative consequences, such as hindered recovery process in people suffering from mental disorders. The tendency to stigmatize manifests itself in the majority of age groups, but the elderly seem to be ignored both in research concerning the phenomenon of stigmatization itself and research on methods of counteracting it. The aim of the study was to describe the experiences of contact between the elderly and people suffering from mental illness in order to recount both the symptoms of stigmatization and the readiness to meet such people. The additional goal of the study was to reflect on the methods of counteracting stigmatization.

Method. A qualitative method based on the hermeneutic and phenomenological thought was used to analyze the data collected from four group interviews.

Results. We distinguished three main themes: (1) "Beliefs about the causes of mental illness", (2) "Emotional attitude towards people suffering from mental illness" and (3) "Ways of interacting with people suffering from mental".

Conclusions. Readiness to stigmatize (blaming, controlling, anxiety) and meet people affected by mental disorders as well as to acknowledge their autonomy was observed in our subjects. We propose methods of combating the stigma such as: acquainting recipients with existential and evolutionary thought, nurturing imagination and encouraging people to confront common stereotypes with stories of people they know.

Key words: stigma, psychoeducation, mental illness

Introduction

Stigmatization

The human diversity can be both creative and stigmatizing. That second diversity driven process is a multidimensional phenomenon occurring when traits and distinc-

tive features that distinguish a given individual from the rest of society are noticed, and as a result of this recognition the person becomes devalued [1]. Corrigan [2] lists the elements that constitute stigmatization: stereotypes concerning specific social groups; prejudices that appear when a person agrees with the stereotype prevailing in society; discrimination, i.e., behavioral responses (avoidance or aggression). One of the commonly stigmatized groups includes people suffering from mental illness [3]. As Goffman [4] notes, everyone needs respect and recognition, but a stigmatized person is denied them both. Experiencing stigmatization is painful and makes it much more difficult to recover from an illness and to function efficiently on a day-to-day basis [5, 6].

Causes of stigmatization

Many interpretations of the causes of the stigmatization of people suffering from mental illness can be found. Evolutionary psychology proposes that it is the consequence of an adaptation which protects humans against extrinsic threats by avoiding those who are characterized by potentially threatening deviations from the norms [7, 8]. However, the complexity of the social environment makes adaptations imperfect. A person who is a bit too sensitive to all possible threats feels fear, overestimating the risk on the basis of imprecise and ambiguous indicators (e.g., strange and incomprehensible behavior, inadequacy, specific appearance) [8]. Existential psychology refers to the concept of anxiety noticing that contact with people experiencing severe disease (such as psychosis) may cause the observer to be afraid of realizing that his existence could potentially be jeopardized by destruction [9]. Treating people affected by mental disorders as significantly different others brings relief, because it constitutes the illusion that the risk does not concern us [10]. Another explanation is that the emergence of prejudices towards those who do not belong to the same social group (i.e., "healthy people") is needed to reduce uncertainty about the surrounding world and the role played in it [11].

Counteracting stigmatization

In recent years, many attempts have been made to counteract the stigmatization of people suffering from mental disorders. Attempts to determine the effectiveness of these methods have shown that they are often ineffective and in some cases even counter-productive [12–15]. Such results were most often found in studies involving education about the biological basis of mental illness [16]. Subjects equipped with knowledge about such etiology expressed greater readiness to benefit from the help of mental health professionals and better recognized disorders such as depression or schizophrenia based on the description of symptoms and less frequently reported that the cause of an illness is a weakness of character. Unfortunately, they systematically showed greater concern about the unpredictability, threatening nature of the people suffering from mental illness and the desire to isolate them [17–21]. Reed and Harré [22]

note that while the presence of genetic explanations is associated with more frequent occurrence of negative attitudes towards the people affected by mental disorders, the psychosocial explanation does not bear such consequences.

The elderly

Old members of society constitute an increasing percentage of the general population around the world [23]. At the same time, we have found almost no studies regarding the elderly's perception and stigmatization of people suffering from mental illness and even less scientific output on the subject of psychoeducational campaigns addressed to people belonging to this age group. Some studies in this area refer to the level of knowledge of the elderly about the causes of mental illness, its course, nomenclature, possible methods of treatment, and the use of psychiatric or psychological help [24–26]. Meanwhile, as noticed by Griffiths et al. [27], the stigmatization of people suffering from mental illness can come from people belonging to every age group. It is crucial not to ignore this problem in the population of older individuals who not only simply interact with the rest of the society but also have a significant impact on shaping the attitudes of future generations [28].

The aim of the study was to describe the experiences of contact between elderly people and people suffering from mental illness and, subsequently, on the basis of the results, attempt to identify manifestations of stigmatization or, alternatively, readiness to meet such people. The research was also guided by the practical goal – to reflect on psychoeducational activities that would reduce the stigmatization of people suffering from mental illness.

Participants

A total of 46 people took part in the study. Subjects were aged over 60, had at least secondary education and were retired. The study consisted of four 1.5 hour group interviews carried out at one of Polish Universities of the Third Age, as part of psychological workshops. Participants signed written informed consent forms.

Method

Subjects were asked to "recall" and "think about the person that was described as, or thought to be, suffering from mental illness" and to draw on the sheets of white paper distributed to them the trace that this person has left in their memory. After this stage, the respondents were asked to see the drawing as the beginning of the story of the person who left it. They could also discuss, ask each other questions and comment on the statements.

The decision to employ this particular form of the study was based on the observation that research exploring the subject of stigma is predominantly based on the

questionnaire method, sometimes enriched with vignettes (descriptions of people with specific diagnoses created on the basis of diagnostic criteria) without reference to real interactions with people suffering from mental disorders [29]. Thus, at the instigation of Brach-Czaina [30], our practical recommendations were to be derived from every-day life – from the world in which we live and in which both stigmatization and the recognition of otherness take place.

The method used to analyze the collected data was rooted in phenomenology and hermeneutics. It was descriptive (seeking to describe the experience of contact and perception of people suffering from mental illness) but also interpretive (based on the assumption that knowing a phenomenon not mediated by interpretation is impossible) [31, 32]. Transcriptions were made on the basis of the audio recordings obtained during interviews. Next, researchers performed a qualitative analysis of the transcripts. The analysis of the collected data consisted of reading the transcripts repeatedly, coding the text of the utterances in MAXQDA (the qualitative data analysis software), making notes and grouping the resulting codes into categories.

Results

Participants shared their stories and recollections with each other and with the researcher. The persons suffering from mental illness were known or related to the participants to varying degrees – they were close friends, acquaintances, distant members of family, or people who were merely observed at some point. Some of the respondents also presented their opinions on the social group of people affected by mental illness.

We identified three dimensions: (1) "Beliefs about causes of the illness", (2) "Emotional attitudes towards people suffering from mental illness" and (3) "Ways of interacting with people suffering from mental illness". Individual dimensions will be presented below and illustrated with the statements of the participants.

Beliefs about causes of the illness

This dimension refers to the different ways of understanding the basis of mental illness in general as well as the alleged causes of falling ill in cases described below.

Illness as an excuse

Some respondents described disorders as ways of escaping from responsibility or as excuses. In their opinion, the symptoms were a manifestation of willingness to derive secondary social benefits from "being affected by mental illness". One example of such alleged benefit is being allowed to ignore personal hygiene and home duties.

> *He justifies laziness with illness. "I do not have to wash, to take care of myself, to have the apartment clean because I'm ill".*

Another participant suspected that the man she mentioned used information that he was suffering from mental disorder to justify his financial inefficiency.

> *He retired, he started to run out of money and he escaped into illness later. It was an explanation for having no money.*

The behavior of people suffering from mental illness is perceived here as a form of fake spectacle, acted out mainly in order to bring some benefits. The lack of improvement of mental health was attributed to bad will or laziness.

However, there were only several statements that described bad intentions as the main cause of falling and staying ill. Participants more often expressed the thought that mental illness is caused by factors independent of the affected person. The alleged causes are presented below.

Hereditary conditions

Participants enumerated genetics as the root of the illness.

> *People in their thirties and in their twenties, or even teenagers, who have some kind of chromosomal tendencies, it happens that they fall into ... This is genetic probably.*

Some of the respondents perceived the causes of mental illness in such a way while talking about people they knew.

> *The illness, schizophrenia, manifested itself – it was genetic, hereditary. Probably this person has a genetic burden because her mother also has very strange reactions.*

However, even when they knew or suspected the diagnosis (e.g., schizophrenia, depression, bipolar disorder) and were aware of the hereditary underpinnings of an illness, many of them also took into account the complex nature of mental illness and sought external causes as well.

Traumatic experience

Many subjects described the occurrence of the illness as a consequence of extremely difficult, tragic events such as losing a loved one. One of them described a woman he met during childhood who became ill after her fiancée became lost at war.

> *I was 5–7 years old when a lady came to visit us. Dressed in a long white dress, barefoot. She behaved very calmly… My mum told me that the lady was the fiancée of my uncle who died in the war. She did not believe it, and she was still waiting for him to come back….*

Another interviewee mentioned a woman who lost her only child.

> *My friend lost her only child and this death affected her life to such*
> *extent that she basically did not regained her psychological balance.*
> *She did not come back to a normal life.*

One of the subjects told us about a friend who, unable to bear the loss of her husband, became addicted to alcohol.

> *Her husband died. She started to look for a relief in alcohol.*

It seems that what connects the above reflections is the understanding of the illness as one of the possible and natural reactions to painful and extremely difficult experiences such as the loss of a person to whom the subject was strongly attached. Illness is incorporated into a narration about a given person – it becomes an element of a coherent story.

Emotional attitude towards people suffering from mental illness

This dimension refers to emotional reactions to people affected by mental disorders whom the participants have met personally, about whom they have heard or reactions to the social group of people affected by mental disorders.

Fear

Some respondents talked about the fear that accompanied meeting (or even the thought of meeting) people suffering from mental disorders. The subjects reported on invasive behaviors manifested by people suffering from mental illness, such as shouting and accusing others.

> *She shouted various things, it was difficult to even understand what*
> *she was shouting. She accosted people.*

Some of the participants commented on the fear of being assaulted by people suffering from mental illness.

> *She threatened her own family, I think that she would cut artery*
> *with a kitchen knife at night if she had a vision that something was*
> *threatening her.*

It was usually based on conjecture.

> *She went to work and what was going on there was not known because*
> *she was probably aggressive to youth. Simply dangerous.*

One participant mentioned the situation in which she was warned by the neighbor and encouraged to avoid meeting the person just because she was suffering from mental illness.

> *She was always wearing a pink turban and shouting very loudly.*
> *I talked with her few times, but a neighbor told me – "She is mentally*

ill" – I was just new, I did not know – "you must be careful so that she would not hurt your son".

Some of the respondents noticed that atypical behaviors of people suffering from mental illness were probably appropriate but for the idiosyncratic and specific realities that they inhabited. One participant commented that personal beliefs of the woman he encountered were sincere and natural.

> *She said she was a princess. She was not playing a princess, so I would say. It was just that she thought it was supposed to be like that. And this princess was convinced that she was a princess. She was so natural. Maybe not convincing because … it's hard to convince others: "I am a princess". But she was honest, she believed it.*

One of the respondents commented on story of a boy who was sent to the hospital after he was presumed to sleep with a knife under his pillow to hurt someone. She searched for a potential alternative interpretation of his behavior, e.g., one in which his anxiety, rather than violent disposition, was the driving force.

> *Maybe he was so afraid and anxious that he kept the knife for self-defense and not because he wanted to attack somebody.*

One participant had an idea that the imagined world of a woman affected by mental illness had an important function – gave her peace.

> *The lady was waiting for her fiancé, even though it was obvious that he went missing during the war. Today, I would tell her to keep waiting for him and he will surely come back. So that she could live peacefully.*

Common to the above reflections is the readiness of the observers to acknowledge the experiences and behaviors of people suffering from mental illness as justifiable as their own. The unusual behavior of the described people does not cause anxiety in that case. Even if the person affected by mental disorder surprised them at first, they tried to imagine and understand their inner world.

Ways of interacting with people suffering from mental illness

This dimension encompasses the participants' behaviors towards people suffering from mental illness and the behaviors they observed.

Controlling

The conviction that people suffering from mental illness need to be tricked into being hospitalized was present in the stories pertaining to individuals affected by

mental disorders. One of the respondents mentioned a situation in which a woman suffering from mental disorder was tricked into going to a hospital. The story was suffused with anxiety – the respondent's grim fantasy was that of a woman who would kill her loved ones.

> *This young woman could be extremely dangerous. And it was necessary to pacify her by deception and lock her up in a hospital. Well, it sounds terrible, but they had to choose between a couple of dead bodies in the apartment and a woman in a straitjacket.*

Sometimes, while thinking about the opportunities for helping a person suffering from mental disorder, the participants suggested that providing such help would be possible only with the use of some form of deception – otherwise such help would be rejected.

> *– But if we wanted a given person to change her behavior, because of the fact that the behavior is dangerous or something? We could not speak to her directly because she would not listen.*
> *– Of course she would not listen.*
> *– Unless we react in such a way that we trick her into thinking something and suggest her something – maybe then it would work.*

Another respondent told us about a person who decided for her husband that he had to be "given away to the hospital". The statement hinted at the total passivity of the husband – the respondent assumed that all the responsibility in that situation was on the wife.

> *A person who develops a mental illness must be hospitalized from time to time to reset it there. Such a person then functions normally for a while, then you notice some symptoms again and you have to give him/her back to reset him/her there. My brother has a friend – his wife has to give him away from time to time. And we laugh at that: "Robert went for a reset".*

The respondents also discussed the issue of introducing compulsory psychiatric diagnostics of people applying for employment in certain workplaces in order to exclude the possibility of performing important functions by people suffering from mental disorders.

> *In some professions, especially some important positions, it should be mandatory to test people because such a man can do a lot of wrong.*

In many of the above-mentioned cases the need to control people who suffer from mental illness and to make key decisions for them seems to derive from the assumption that those people are passive and not able to choose what is good for them. One of the quotes was particularly clear.

> *The mentally ill do not think, so you always need somebody that decides for them.*

It seems that the willingness to control the mentally ill and protect against potential threats is common in the above-mentioned reflections.

Hospitality

Data analysis also allowed to draw a picture of the respondents as ready to meet people affected by mental disorders, recognizing their distinctiveness and autonomy. The respondents recall memories of how they accompanied mentally ill people with no intent of controlling them. One person recalled her childhood memory in which a man who was suffering from mental disorder was welcomed into her family house. She remembered how casual his visits to their house were and at the same time mentioned her puzzlement brought about by the man's presence.

> *He used to come to us, sit with us. Our mother gave him some food, dinner. He ate so… so voraciously, he was squelching, so, so ... And at some point when he was eating like that – he had false teeth – and he pulled those teeth out ... I tried to get my teeth out and I was just asking what ... I just did not know why he could get those teeth out… and it stayed in my memory that way.*

Other participant shared her own story of asking a homeless woman to sleep at her place.

> *Everyone said she was mentally ill. She was a charwoman, homeless and had a room in the basement. I invited her to my flat and made a bed out of a convertible armchair in the kitchen and she slept one night with me.*

One of the respondents recalled his relationship with an ill colleague and told us about the support he gave him in pursuing his passion.

> *We contacted each other. To the extent that I tried to publish his work – because he considered himself a poet, a writer ... even the incarnation of Wyspiański. I do not know much about it, but at his request and as an IT specialist, I produced his poems and stories at home. I still have a lot of those things at home.*

In these situations, the thought that the person is affected by mental disorder does not overshadow his/her other traits, does not make the meeting an attempt to change someone, or to protect against the potential threat coming from his/her side.

Discussion

In our research, the predominance of statements concerning external causes of illness over those describing biological determinants was revealed. That is consistent with the results of many other studies, summarized in a meta-analysis by Read et al. [16].

Obtained results also suggest that the capacity for controlling the occurrence of a disorder and its development is sometimes overestimated, which may even take the form of accusation (e.g., laziness or weakness of character). Blaming people affected by mental disorders is a common and serious aspect of stigma and it was the object of interest of the investigations described above [12, 34]. However, it seems that anxiety that constitutes the stigma, described in the dimension "Emotional attitudes towards people suffering from mental illness", manifests itself as a result of a sense of incomprehensibility, a strangeness of what we confront on a daily basis. Filling this gap with knowledge about the names of symptoms and diseases, as well as biological aberrations underlying them is insufficient (or even counter-effective), as it does not refer to what is close and familiar to the recipients. Focusing on the illness itself and the skill of naming it or recognizing its symptoms rather than on the individual suffering from it can even increase the social distance [33]. We think that more appropriate forms of discourse than the biological one are available. The solution that should be considered is psychoeducation referring to existential and evolutionary thought. Both of these fields are characterized by indicating that man has a specific biological structure, but he is also shaped by the environment in which he is brought up, by the events that he encounters and ultimately by the results of the choices he makes himself [9, 35, 36]. Such an approach does not diminish any of the factors, but at the same time does not provide a basis for assigning a paramount role to one of them, obscuring the ill person. In this approach, madness is the answer to the environment in which someone grew up and a way to survive in it despite everything that threatens him/her [10].

It seems that the proposed approach to mental health and disorders within psychoeducation could strengthen the way of thinking which already manifested itself in our research and was classified as "Acknowledgment". Respondents who seemed to acknowledge people suffering from mental disorder were wondering about the meaning of the illness and trying to imagine the inner worlds of the suffering individuals. Perhaps that natural tendency to try to understand the illness in the same way that we understand other everyday experiences and phenomena should be strengthen by stimulating imagination. At first, imagination usually conjures up visions of the most accessible scenarios – those related to threats and perils. In order to acknowledge the others' unique independent world, it is necessary to nurture imagination suggesting that behind the layer of the visible and incomprehensible there is the fundamental desire to exist shared by both healthy and suffering humans. The phenomena that we recognize as symptoms can as well be responses to aspects of reality that we cannot see as the

observers [37]. Psychoeducation could encourage recipients of psychoeducation to look beyond what they can see (behaviors that do not fit 'my' world) and try to fathom what is hidden (the circumstances to which the illness is the answer). Afterwards, they can think that the woman is looking for her fiancé, even though it is known that he is dead, because otherwise she could not live anymore – this creates a sphere of shared experiences and a platform for meeting each other.

Strengthening the acknowledgment and alleviating the anxiety may have a serious practical consequences described in "Ways of interacting with people suffering from mental disorder". Experiencing strong anxiety was often accompanied by a desire to control and thus exclusion. Previously many researchers have observed destructive consequences of the popular assumption that people suffering from mental illness should be kept away from society because they are dangerous, life decisions should be made for them because of their irresponsibility and they should be looked after because of their childishness [2]. People who were ready to acknowledge other ways of being showed the readiness to encounter people affected by mental illness, recognizing their autonomy. The nature of the category "Hospitality" is well reflected in the suggestion to not to talk "about the person suffering from mental illness" but rather "to him/her" and "for him/her" [10]. The acknowledgment of the other person, respecting his/her separateness and allowing him/her to decide for himself/herself whether and how close he/she is to other people is necessary to create the space for meeting [38].

Many statements of respondents were stigmatizing, but inspiring amount of non-labeling thoughts was also revealed. It is possible that the format of our study itself was the cause of such results – it encouraged participants to talk about specific people – stereotypes were present in the study to the greatest extent whenever participants talked about people suffering from mental disorders as an abstract group or when a participant was not acquainted with the life history of a given person. As Corrigan et al. [39] notice in their meta-analysis one of the most effective ways to counteract the stigmatization of people suffering from mental illness is to discover the stories of their lives. Similarly, Hawke et al. [40] and Chang [41] encourage psychoeducation about mental health to make use of narrations about people suffering from mental illness instead of, e.g., detailed information about disorders with no specific personal narratives brought into play. It could be seen as another inspiration for psychoeducation – to encourage people to recall real individuals suffering from mental illness.

Bradbury-Jones et al. [42] notice that both Heidegger and Gadamer assumed that every act of understanding is an act of interpretation which is inescapably rooted in individual experience. Thus, our study was not aimed at obtaining a pure description of experience of understanding persons suffering from mental disorders. A description of how the person was remembered took into account reflections and experiences of the subject and the specific context of the study in which the memories were recalled (presence of other respondents and their memories, the metaphor of a trace as the starting point of discussion).

Conclusions

Many subjects revealed stigmatizing beliefs about people suffering from mental illness and at the same time many of them showed the readiness to deconstruct the stereotypes or prejudices – both their own and those of other respondents. Further exploration of this second type of interacting with people affected by mental illness can be particularly important for designing anti-stigmatization programs. Modifying and undermining prejudices and stereotypes combined with the strengthening of the willingness to meet and dialogue can be more effective than focusing only on fighting the negative aspects of interactions with people suffering from mental illness.

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Address: Anna Bańbura
Jagiellonian University
Institute of Psychology
30-060 Kraków, R. Ingardena Street 6
e-mail: anna.banbura@doctoral.uj.edu.pl