Preface

Stigma;

Pronunciation: /ˈstɪgmə/

noun

a mark of disgrace associated with a particular circumstance, quality, or person

- *Oxford Dictionary, 2011*

About 30 to 50% of adults will experience a mental illness at some point in their lives (Carney-Doebbeling, 2007). More than 50% of them experience moderate to severe symptoms (Carney-Doebbeling, 2007). In fact, 4 of the 10 leading causes of disability among people aged 5 and older are mental health disorders (Carney-Doebbeling, 2007). Unfortunately, despite this high prevalence of mental illness, only about 20% of people who have a mental illness receive professional help (Carney-Doebbeling, 2007). The term "mental illness" conjures different images for different people all over the world. A raving lunatic in a straight jacket, a witch, a demon, a prophet, cursed, gifted, a disgrace to the family. There is no denying that a stigma has been placed on these people throughout history and in modern society around the globe. This statement can be proven through observation of people in different cultures and their reactions and opinions towards the mentally ill. Psychiatric hospitals are called lunatic asylums, crazy houses, padded cells, rubber rooms, snake pits, mad houses, loony bins, cuckoo's nests, psycho

wards, booby hatches, nut houses, and funny farms, while the sufferers within get called crazy, cuckoo, batty, or whacko. Where is our compassion? The purpose of this report is to focus on the perception of what mental illness is in a sample of developing countries. The intention is also to examine the treatment methods within these countries as they are directly created based on stigmas and biases of the original perception. This paper will investigate the role religion has in prejudice, particularly Scientology which claims to be expert the ways of the mind and are fervent believers that there is no need for psychiatry. They are by far one of the most opinionated religions on the topic of their perception of mental illness. This paper will explore whether the bias shown in different religions is justified and investigates the logic behind their view. Finally this paper will propose solutions that might counter this worldwide stigmatization and ill treatment of these people.

The definition presented at the top of this paper is a textbook classification of stigma. But stigma becomes much more than that when related to societies and their mentally ill inhabitants. Perception of mental illness can be crippling in its naivety and hinder the cohesion of a population. Human rights are slandered when bias and discrimination occur. This is an issue because as insight is shared and views are explored from around the

world, this disease is greeted with as much stigma and hatred as a different ethnicity or different religion can be. People in the world are hated and killed for how they were born without any consideration about how to understand and help these people. A balanced approach that combats the various myths about mental illness with factual information would be the best way to change the dynamics of this widespread hate.

Summary

This report will use information from a variety of places, namely, information from the Internet. News websites will be used most frequently, especially when looking at specific cases where religion and culture influences individuals. BBC news, the New York Times and the Guardian UK are three examples of reliable news coverage associations that have in the past done articles on the topic of cultural perception of mental illness. The Psychiatry Online Database and Psychiatric Times will also be utilized throughout this report to give understanding on the topic. Another example of sources that will be applied in the report will be the use of personal blogs from experts including Brian Spegele, who specializes in analyzing China's mentally ill. Also information from Giuseppe Raviola, who is the director of mental health and psychosocial services for Partners in Health will make it's way into this report, particularly the solutions. His work and research will also be expanded upon through my exploration of an expert on this issue considering his work and expertise qualify him for expert recognition. Through case studies, the role of religion, and relating back to Canadian involvement, the stigma and views on mental illness will be investigated and in the end, the recommended solutions will be the result personal opinion and of the above noted research.

Background

Stigma has four observed steps: 1. Labeling someone with a mental condition 2. Stereotyping those with this condition 3. Societal division resulting in a loss of status: the superior "us" versus the inferior "them" and 4. Discrimination on the basis of the created label (Epigee, 2009). Although it is important to label mental illnesses specifically in order to dictate and provide care, we must be careful to unleash the stigma attachment. Up until recently, breast cancer was a secret shame. When people began to speak in an open manner of breast cancer and even campaign for this cause, it lost the embarrassment (Weber-Rabehl, 2006). Physical ailments have always been seen as no fault of the person. Physical disability invokes empathy and support. Talking about mental illnesses in a frank and respectful manner is the best way for these diseases to gain a measure of positive public regard. This ultimate goal has had a tumultuous journey though, to say the least.

Mental illness is a brain disease and therefore has been occurring since the inception of mankind’s existence, even if people didn’t realize what they were experiencing. The efforts to intervene with the mentally ill are as old as mental illness itself. Perception has metamorphosed along with the times as well. For example, by most people’s definition of

mentally ill, if Jesus Christ roamed the earth today he'd be most likely institutionalized and deemed nuttier then a fruitcake. He believed himself to be a king, he claimed to be able to have these special powers - healing the sick and walking on water, all these things that if you had not been witness to the miracles, you wouldn't fall for right away. Treatment has evolved as well. There is evidence from Neolithic Stone Age times of the practice of trepanation (cutting large holes into the skull), possibly as an attempt to cure ailments that may have included mental disorders (Brothwell, 1963). Greek, Roman and Spartan societies sought, by and large, to "contain" the problem of mentally ill children. Infanticide was the preferred method of the time, where they would simply exterminate abnormal children (Weber-Rabehl, 2006). The rise of Christianity, which went hand in hand with proclamations against the selling, killing and mutilation of children with a mental illness, caused not only a decline in these practices but also a change in the way in which mental illness was perceived. Gears shifted from containment and annihilation towards help.

In the Middle Ages the mentally ill were given the job as clowns (Weber-Rabehl, 2006). This was seen as a kindly gesture because without this job, the mentally ill would have no place in society. This type of pendulum effect swung from suppression to aid, constantly back and forth since the beginning of time. The Colonial American society referred to

those suffering from mental illnesses as 'lunatics" which interestingly enough was derived from the root word lunar meaning, "moon" (Leupo, n.d). Through astrological reasoning it was believed that insanity was caused by a full moon at the time of a baby's birth or a baby sleeping under the light of a full moon (Leupo, n.d). Colonists declared these lunatics possessed by the devil, and usually they were removed from society and locked away (Leupo, n.d). Around the turn of the 19th century, Europeans introduced a new approach to the treatment of the mentally ill known as "Moral Management" (Leupo, n.d). This approach was based on the belief that the environment played a vital role in the treatment of the mentally ill. Creating a more domestic feel, beds, pictures and decorations replaced shackles, chains and cement cells of the colonial era (Leupo, n.d). This was done in an effort to examine whether a safe comfortable environment promoted mental wellbeing. Phrenology was introduced at this time, which is the practice of studying the shape of the brain to explain illnesses and render diagnosis as well as hypnosis (Leupo, n.d).

Problems surfaced however, with patients becoming unruly due to lack of restraints, and concern arose with how patients were to occupy their time. To combat these concerns, work programs and recreational activities were devised for patients in asylums. This was an attempt as well to integrate and bridge the gap between society and the hospital (Leupo,

n.d). Another pivotal point in the history of Western mental illness was the American Civil War. After the Civil War in America, a great number of servicemen suffered from postwar trauma or post-traumatic stress disorder (McPherson, 2007). Upon their return home they flooded mental hospitals causing overcrowding of the likes that had never been seen before (McPherson, 2007). Although, the public eye watched very closely how their 'war boys' were treated, institutions had no choice but to reinstate old procedures due to the serious issue of overcrowding in order to maintain control. Restraints and shock therapy were reintroduced, along with new drug treatments such as opium (Leupo, n.d). The Civil War also shed new light on mental illness as a disease. It became something that could happen to anyone, even courageous war heroes. Shortly after the asylum population explosion in the mid 1900s, when mental health treatment was arguably at its worst, an apparent salvation emerged. Psychotropic medication was pioneered. In 1954 the medical community introduced an anti-psychotic drug called Thorazine for the treatment of the mentally ill (Leupo, n.d). In rapid succession, other psychotropic medications became available, making it possible to cut substantially the length of time patients stayed in mental institutions. This breakthrough led to a significant decline in asylum populations, and the gradual discontinuation of less humane treatments and procedures such as

lobotomies and electro-convulsive shock treatment (Leupo, n.d). In the 1960s' state institutions changed their procedures resembling the previous "Moral Management" revolution of the 19th century (Weber-Rabehl, 2006). There was an emphasis on protecting the human rights of the mental patients that had historically been overlooked. Treatments were geared at the individual and proved to be more effective then group cure-alls (Leupo, n.d). There also was a notable move to de-institutionalize mental patients. In 1960 there were over 500,000 patients in mental institutions in America (Leupo, n.d). It had become increasingly clear that there were many inmates in asylums in custodial care who were able to function in society with adequate outpatient care. Institutions continued to provide 24-hour long term in-patient care, but now introduced outpatient services, day and night hospitalization, diagnostic services, pre-care and after-care, and more extensive training and research (Leupo, n.d).

Role of Control

Frequently we make false generalizations – not through malice or hatred, but just because, in many cases, it is easier to do so than to understand the real differences and complexities of our world. When it comes to the perception and ultimately the prejudice associated with

mental illness around the world, the social norm dictates public reception to the disorder and ultimately the behavior that ensues as a result (National Aids Trust, 2003). Psychologists who work within this school of thought suggest that prejudice is "a consequence of our natural tendency to categorize the world in order to make sense of it. Such stereotypes are not based on fact but rather on what we think is right from our limited experiences and upbringing" (National Aids Trust, 2003). Humans naturally distance themselves from what they perceive as "abnormal" and this can be exemplified through various cliques and reactions towards "outsiders". Mentally ill often fall into these categories. Prejudice, in many ways, is a fear-based subconscious survival strategy that dictates what a person feels and how they react. The drive to completely and quickly divide the world into "us" and "them" is so powerful that it must surely come from some deep-seated need. The exact identity of that need, however, has been subject to debate. Henri Tajfel, of the University of Bristol in England, and John Turner, of the Australian National University, devised a theory to explain the psychology behind a range of prejudices and biases (Winters, 2002). Their theory was based, in part, on the desire for a person to lift their self-esteem (Winters, 2002). A way to accomplish that is to be part of a distinctive group, like a winning team; another is to play up the qualities of an individual's own group and denigrate the attributes of others so that

it is portrayed that one group is better- the two groups in this issue being sane and mentally ill (Winters, 2002). Tajfel and Turner called their insight "social identity theory," which has proved valuable for understanding how prejudices develop. These associations come out of human nature's natural sense to fear- fear being the absence of enough knowledge to feel comfortable (Winters, 2002). Fear can easily become a learnt behavior. All animals can be conditioned to fear. Humans are often conditioned through experience and or fervent warning on a subject. Media in society plays on these two factors and in turn takes some control on the rational behind people's bias of others, particularly the mentally ill (Winters, 2002). The fear of the mentally ill and the desire to control it has been shown in research to potentially be a symptom of the fear of the known and learnt (Eswaramurthi, 2006). This theory expands on the cliché conception that fear of the unknown is at the root of mankind's insecurities and desires for dominance. How can one fear something which they have not seen or of whose pain or severity they have had no personal experience? Society reads about horror stories of the mentally ill killing innocent people or hearing voices or doing strange things and these incidences conjure up emotion, which drives the desire to control the cause of the fear (Eswaramurthi, 2006). Fear, especially fear of the mentally ill, manifests when it begins to hit close to home (Eswaramurthi, 2006). By putting

these people- these sources of fear, into seclusion and isolation and doping them up with medication, society gains control of not only the issue since they control the treatment and ultimate perception, but also it becomes and attempt to gain control of their fear.

In Ancient Greece bodily signs or 'stigmata' (the derivative of which is the word "stigma") were cut and burnt onto people's bodies to mark them as mentally dissimilar (Crisp, 2003). It is no longer common practice for people with mental illness to be physically mutilated as differentiation, but the derogatory attitudes that has been exemplified through much of society today can be just as damaging.

Genetic makeup also has control over this issue. It decides who will become mentally ill and effects how they will act in society. Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are abnormally balanced, messages may not make it through the brain correctly, leading to the manifestation of mental illness symptoms (Kim Foundation, 2011). Other biological factors that influence the display of mental illness include infections and exposure to toxins, brain defects and injuries and prenatal damage (Kim Foundation, 2011).

While social norm dictates the control over when and how a perception is conceived, individuals are craving control. People desire their own knowledge and understanding of things in order to make their own opinions. Sufferers of mental illness are the people who desire and deserve control over their life. They should be able to decide what treatment they will receive and how they deserve to be treated- not some cultural guidebook or learnt human reaction.

Expert on the Issue: Giuseppe J. Raviola

Giuseppe J. Raviola, MD, is board-certified adult and child/adolescent psychiatrist. He is also an instructor in psychiatry and in global health and social medicine at Harvard Medical School and the medical director of the Psychiatry Quality Program in the Department of Psychiatry at Children's Hospital Boston (Department of GHSM, 2011). In his role at this institute he provides oversight of the Department's patient safety, quality, and outcomes initiatives, and works with various departmental services to assess and improve the quality of patient care provided (Department of GHSM, 2011). All this know-how he has showcased for his career has led to sizable expertise in the area of global mental health, which he explains as a passion of his (Department of GHSM, 2011). One cause he has been working closely with over the years

is providing solutions to disaster torn Haitians and changing the population's view on this developing crisis. Raviola, who is the director of mental health and psychosocial services for the Boston-based Partners in Health (PIH), works with this organization and runs 10 hospitals in Haiti (Sontag, 2010). His observations have been eye opening to the mental health professional community. In an interview for the New York Times, he notes "inside this city's earthquake-cracked psychiatric hospital, a schizophrenic man lays naked on a concrete floor, caked in dust. Other patients, padlocked in tiny concrete cells, clutched the bars and howled for attention. Feces clotted the gutter outside a ward where urine pooled under metal cots without mattresses" (Sontag, 2010). This was one of the first indications to the world that this was the state of mental health care in Haiti after the earthquake of 2010 (Sontag, 2010). Raviola has been spending time in Haiti since the earthquake to encourage the Haitian Health Ministry to incorporate mental health care into the primary health care system and to make it available throughout the country (Sontag, 2010). He believes that the quality of the population's psyche and treatment options are of utmost concern in rebuilding the country's social infrastructure. At the moment, the need for psychological first aid and emergency psychiatric treatment is so acute that PIH's foreign psychiatrists are seeing patients, setting up programs and rapidly training Haitian

doctors, nurses and community workers in everything from psychopharmacology to group relaxation techniques in order to improve the treatment of the mentally ill in Haiti, who are put at lowest priority and treated like cattle (Sontag, 2010). Raviola work has been an instant improvement to this area of need because Haiti had a total of 10 psychiatrists and 9 psychiatric nurses working in the public sector prior to the earthquake (PIH, 2010). This is a desperately low number considering Haiti is a country with a population of over 9 million people (PIH, 2010). Prior to the quake, there were two psychiatric hospitals in the capital city of Port-au-Prince, one of which was dilapidated and in desperate need of massive repairs (PIH, 2010). Prior to the earthquake, the Haitian government understandably focused on combating infectious disease, and maternal and infant mortality (PIH, 2010). Psychiatric and mental health services received little government funding. That all changed following the earthquake. The Haitian Ministry of Health declared mental health a national priority. In coordination with the Haitian government, PIH's mental health and psychosocial teams have established an active presence in the four resettlement camps for displaced earthquake survivors in Port-au-Prince (PIH, 2010). Haitian perspective of mental health has been changing since the disaster as the reality that mental health can happen to anyone (PIH, 2010). Post traumatic stress disorder has become a

frequently observed condition amongst citizens following the traumatic quake. With so many lives lost, so many displaced, over a million left without homes, hundreds of thousands of people suffering life-altering physical injuries, and in an unstable environment, it's not just those with pre-existing mental health issues who are in need of care, and the government of Haiti is starting to see this (PIH, 2010). It’s from this national realization that Raviola has focused his efforts and aimed his teachings of inclusion and care (PIH, 2010). Raviola takes pride that he is leading a team of people who’s purpose is to advocate this change in mindset, encouraging Haiti to see the mentally ill as everyday people instead of brutish animals. His efforts have been met with great success and he and PIH have inspired many similar efforts around the world such as The Dr. Mario Pagenel Fellowship in Global Mental Health Delivery, Inshuti Mu Buzima in Rwanda and Zanmi Lasante which is another organization in Haiti.

Case Studies:

Nigeria

There are around 130 working psychiatrists in the whole of Nigeria (AGB, 2009). Nigeria has a population of approximately 155,215,573 (Index Mundi, 2011) with prevalence rates of around 20-28% for diagnosable mental health conditions in the general population (AGB, 2009). This means that there are at least 25 million people who would benefit from mental health services in Nigeria that can't receive treatment because of the astonishingly low ratio of patients to psychiatrists. As surprising though it may seem to a Westerner, much of Nigeria is content with this ratio. In a study conducted by Nigerian born psychiatrist Dr. Abiodun Adewuya and professor at Obafemi Awolowo University, Roger Makanjuo, the results showed the majority of Nigerians preferred traditional methods of healing as opposed to western medicine (Adewuya, Abiodun and Obafemi Awolowo, 2009). Adults selected from three Nigerian communities completed questionnaires on their perceptions regarding causes of, stereotypes of, and treatment options for mental illness. The preferred treatment option was spiritual healers, endorsed by 41% of respondents. 30% endorsed traditional healers, and 29% endorsed hospitals and Western medicine (Adewuya, Abiodun and Obafemi

Awolowo, 2009). Western medicine would include the use of hospitals, psychotropic medication, and psychotherapy, traditional practices have herbalists as the providers of medication and healing, and spiritual healing involves prayers and visits with spiritual leaders (Adewuya, Abiodun and Obafemi Awolowo, 2009). Spiritual healing practices are the most preferred form of treatment in Nigeria and what the study fails to include is that it is the most favoured because the methods of spiritual healing feed right in to the stigma towards mental illness that has been shown throughout Nigeria as the norm. While prayers and visits from spiritual leaders sounds pleasant and beneficial, in Nigeria that is often not the case. In Nigeria, especially in more rural areas, which is most of the country, mental illness and witchcraft are two synonymous terms. Nigerian Bishop Sunday Williams says during a British Television Channel, 'Channel 4' documentary, that Nigeria has "23 million witches and wizards" (Ayodele, 2009), an astonishingly close number to the amount of people in Nigeria that would benefit from mental health services (the 25 million mentioned earlier).

In a society where the fear of witchcraft is so deeply rooted, it is used as an explanation for a variety of occurrences such as bad harvests, illness of the male in the family, deterioration of farmlands and the symptoms associated with acute mental illnesses (C.D, 2002). Since a

witch is said to intend harm to family members or members of the community, in a closely-knit commune such as rural and Southwestern Nigeria, they are viewed as especially dangerous and subject to often times violent exorcisms (C.D, 2002). Often in Nigeria these exorcisms are geared towards children because a parent will notice something peculiar about a child a want it to be reformed as early as possible (Houreld, 2009). The rapid growth of evangelical Christianity in Nigeria may play a part in the ferocity of the exorcisms (Houreld, 2009). Christianity, especially in the past, looked at mental illness as possession by the devil (Doebbeling, 2007) much the same way Nigerians look at witchcraft. Churches outnumber schools, clinics and banks put together in Nigeria so it isn't surprising that religious and spiritual healing is sought after when a parent is concerned for their child's wellbeing (Houreld, 2009). But this paranoia of mental illness and witchcraft has become incredibly superstitious. In 2009, 8-year-old Abigail Eyekang was accused of witchcraft because she liked to sleep outside on hot nights (Houreld, 2009). Her mother assumed this habit meant she wanted to spend her nights outside as an indication that she wanted to commune with other people who slept outside at night (homeless mentally ill) and fly off to join a coven (Houreld, 2009). Her mother later abandoned her and has refused contact for fear that her mental state will rub off on her like "an infectious

disease" (Houreld, 2009). For families that can afford an exorcism, treatments include the sawing off of the top of the head to allow bad energy to escape (Houreld, 2009), sodium hydroxide otherwise known as caustic soda poured into the eyes to blind and prevent the sufferer from seeing hallucinations that are symptoms of not only witchcraft but also mental illness (McVeigh, 2007), setting the sufferers flesh on fire to burn the witchcraft off their skin (Houreld, 2009) and forced consumption of cement- a porous material meant to absorb the evil from the inside (Houreld, 2009). These are just a few of the many examples of child exorcism based on, in many cases small abnormalities, like the desire to sleep outside in Abigail Eyekang's case, mentioned previously (Houreld, 2009). Due to the stigma attached to mental illness- that it is something to be feared, cases of innocent children being exorcised have also occurred (McVeigh, 2007). Any abnormality or uniqueness is seen as cause for exorcism. These beliefs, despite the advancements in science and technology that offer explanation for the symptoms the society finds so fearful, are still being consciously promoted in Nigeria. The masses still prefer spiritual healers and until more education is brought to this area, there will be countless more victims of unnecessary exorcising as treatment because of this country's deeply rooted perception of mental illness.

Nicaragua

Mental health services in Nicaragua are organized along progressive community-based lines with an emphasis on prevention and accountability (Harris, n.d). The people of Nicaragua feel that mental illness is something that a person's actions are reprimanded with (Harris, n.d). Psychotropic medication is rarely used in Nicaragua for ideological reasons and the use has been declining since the 1980s (Harris, n.d). Cases of schizophrenia or depression- wide spread in developed countries are minimal here (Harris, n.d). Also, the vast population of homeless peoples with mental health problems seen in Western cities are missing from the streets of Nicaragua. This has been attributed to the stronger sense of community in Latin American countries (Harris, n.d). Since psychological distress is seen in a social context, there is an emphasis on group approaches. Individual therapy is almost never used (except occasionally for post-traumatic stress disorders) but overall, the people in Nicaraguan communities band together to fight mental illness (Harris, n.d). The people of Nicaragua won't let their loved ones suffer alone or in silence, even if it is to their

determent, as shown in an example of the Miskitu tribe, an indigenous tribe.

The Miskitus, a group indigenous to the Atlantic coast of Nicaragua and Honduras, don't have a word for mental illness. Instead, ailing people are thought to be out of balance with the spirit (Ross, 2006). Grisi siknis, the Miskitus' best attempt at a phonetic spelling of "crazy sickness," causes those afflicted—mostly young Miskitu women—to alternate between a trancelike state of semi-consciousness and periods of frenzied behavior (Ross, 2006). During the latter, victims often rip off their clothes, flee into the forest or the murky, fast-flowing river, and appear to develop superhuman strength (Ross, 2006). In such a crazed state, these women are difficult to stop and are prone to cause harm to themselves and others (Ross, 2006). Western doctors are at a loss as to how to treat this mysterious illness (Fell, 2009). Many psychiatrists believe that grisi siknis belongs to a class of disorders commonly known as "culture-bound syndromes" (Fell, 2009). Examples of culture-bound syndromes include pibloktoq, a disorder similar to grisi siknis that is unique to the Inuit, and the suitably named amok, which is particular to Malaysians and involves periods of brooding followed by outbursts of violent, aggressive, or homicidal behaviour. Dhat in India, characterized by large losses of semen in men, who feel weak as a result. In Japan, taijin kyofusho causes people

to have an intense fear of their own bodies, and in Southeast Asia men and women suffer from koro, which is the fear that one's sexual appendages are being withdrawn into the body and will be lost. Bulimia and anorexia are some Western examples of culture-bound syndromes (Ross, 2006). These types of mental illness are unique because they are unusual and unexplainable to professionals from other cultures. Therefore, the techniques implemented by Miskitu healers provide the best results and prove that western medicine is not the "be-all-end-all" cure.

A method of healing for healing that has been practiced in Nicaragua for over 150 years requires the healer to erect painted sticks with charms tied to them around the inflicted, blow tobacco-smoke over them while speaking to the spirits and requesting their mercy, to make a bubbling with a tobacco pipe in a calabash of water which the inflicted was then made to drink, and to tie a knotted string round their neck, on every knot of which was a drop of blood from the healers tongue. For as many days as there were knots the patient must not eat the meat, must suffer no one to pass to windward of them, and must not see a woman with child (Ross 2006). There is also the use of herbs and candles, in the performace of a cleansing ceremony on sufferers and, often, on their houses as well - akin to an exorcism (Fell, 2009). The family members of the inflicted are not prone to abandonment when faced with grisi siknis (Fell, 2009). Even if it

they need to physically restrain the inflicted in shackles, they will in hopes that they will one day be able to cope with a normal life (Fell, 2009). There is a general destigmatization of psychiatric patients and their integration into the community. Although Nicaragua has limited resources as far as mental health care is concerned, their open acceptance and desire to treat mental illness as humanely as possible have made them a model of development.

China

Approximately one out of 13 people in China suffer from mental illness, yet only a few of them are conscious of their problems, and even fewer have received any appropriate treatment (Jin, 2009). After doing the math, that statistic ends up being around 100 million mentally ill people in China, but due to the fear of prejudice, many of those will never get the help the need (Jin, 2009). China has just 1 psychiatrist for every 100,000 people (Elnhorn, 2004). And the Chinese are making no attempts to rectify this ratio. Norman Sartorius, former director of the World Health Organization's mental-health program, is quoted as pointing out that the Chinese and other Asians have tended to regard mental illness as

something that plagued other places but not their own countries. "It's a problem of the West," he says of the way the argument is characterized. "It's their disease" (Elnhorn, 2004). Mental illness has become something of a shame that has been bred into the Chinese culture. Culturally, most Chinese tend to hide their feelings in comparison to their western counterparts. Indeed, there is a famous Chinese saying, which says, "family shame should be kept inside the house" (Kwok, 2002). There is also a perceived criminalization of mental illnesses which has helped lend taboo status to such disorders in recent years, with many in China now calling on the government to work to change public perceptions after many years of keeping tight lipped on the subject (Spegele, 2010). Considerable discrimination continues to plague those who seek treatment in China (Spegele, 2010). People are uneducated on mental illness and unwilling to discuss it, so progress is at a standstill through much of the country, and in a country of 1,336,718,015 (CIA, 2011), solidarity is impressive. There is also a lack of knowledge - 60% of Chinese people interviewed in 2010 by Dr. Michael Phillips for the magazine *Lancet,* had never heard of the word "depression" (Cheung, 2010). And this lack of knowledge has come with a price.

In China, 75 percent of people who committed homicide who had been psychiatrically evaluated suffer from severe mental illness (Yang,

2010). But we must remember to take into account that many murderers are not evaluated, another example of Chinese disinterest in the mental health of citizens. On the morning of March 23, 2010, Zheng Minsheng, an unemployed surgeon, butchered a group of children gathered at the gate of Nanping Experimental Elementary School in Fujian Province with a long knife. Eight were dead and five seriously injured. He was executed on April 28, only 36 days after the killing (Yang 2010). No forensic psychiatric evaluation was done to try and understand this man and his mental state (Yang 2010). If one had been taken, possible ideas on prevention methods could have been examined but with a culture that prefers to ignore psychosis, nothing was achieved from his case. According to Lin Chiu, a veteran pharmacist at the Castle Peak Mental Asylum in Hong Kong, "Many Chinese have a very vague idea as to what mental illness is. To a lot of them, they tend to relate mental illness to violence, with little knowledge that there are various degrees and types of mental illness" (Kwok, 2002). This is because mental illness only rears it's head to society when the inflicted has been without treatment to the point where they have reached instability. With such a discriminatory attitude towards mental illness, it seems that there would be little hope for employment if the employer finds out that the employee has a psychiatric history; another reason to fear seeking help.

Religious Aspect

Religion has become intertwined with mental illness in many ways for many years. Religions have their own perceptions of mental illness and treatment for it. There are many examples where religion has influenced individual perception of these conditions.

An example of this is the manifestation of OCD in Egyptian Muslim women. The female gender in the Muslim culture is surrounded by so many religious and sexual taboos that women become full of worries, ruminations and cleansing compulsions and are considered therefore more susceptible to develop OCD (Okasha, 2004). Muslims are required to pray five times a day. Each prayer is preceded with a ritualistic cleansing process, which involves washing several parts of the body in a specific order, each three times. Any form of excretion or ejaculation invalidates this cleansing and, for some radical Muslims, any contact with the opposite sex does the same (Okasha, 2004). Women are not allowed to pray or touch the Koran during their menstruation, after which they should clean their bodies through a ritualistic bath (Okasha, 2004). The prayers

themselves vary in length and consist of certain phrases and *suras* from the Holy Koran that have to be read in a certain sequence (Okasha, 2004).

The emphasis on routine and cleanliness is the cornerstone of most of the compulsive rituals. The number of prayers and their verbal content can be the subject of scrupulousness, checking and repetition. These ritualistic cleansing procedures can also be seen as a source of these OCD obsessions and compulsions since it seems almost adherent to the Muslim way of faith. The religious atmosphere in Egypt doesn't cause OCD, but through research it has been shown to influence the content of the women's obsessions and compulsions, and the meaning they attribute to them (Okasha, 2010). Could living in a world where religious rituals reign supreme make a person more likely to develop OCD or any other type of mental illness? Perhaps. But most religions are hardly thrilled at allegation.

There are cases where religion has been blamed for acts of insanity. For example, the case of Andrea Yates in 2001, who murdered her five little children because she thought Satan had possessed her and was soon going to possess her children. In her mind, if she murdered her children before "the age of accountability" they would all go to heaven. She thought she'd be executed for the murders and Satan would die with her (Ramsland, 2010).

In a similar case, which resembles the story of God telling Abraham to kill his son so closely, Deanna Laney murdered two of her 2 of her sons by stoning them to death and then leaving her third boy severely handicapped on Mother's Day weekend in 2003. She did this because she thought God wanted her to do it to "prove her complete and unconditional faith in Him" (Ramsland, 2010).

People who hold strong faith also see religion as the cure and fundamental treatment to mental illness. In a study printed in the British Journal of Medical Psychology 1999, Muslim's were shown as the group that most strongly favoured religious intervention as the main treatment for mental illness (Cinnirella and Loewenthal, 1999). In the sampling of surveyed individuals, Muslim R8 commented " . . .In our teaching, when we have a problem we concentrate on it and talk to Allah about it and ask for help from Him. When someone has faith in Allah and talks to Him about a problem it lifts all sorrow and gloomy moods because the person is sure that Allah knows they have asked for help, and He will help them. It brings positiveness in life. If someone doesn't have all this they will be depressed for sure" (Cinnirella and Loewenthal, 1999). Muslim R9 supports this concept when he is quoted as saying, "It does not matter how depressed you are, if one can divert your attention towards prayer, the feeling of

helplessness and loneliness can disappear . . .giving all problems to Allah and having faith in Him is very therapeutic" (Cinnirella and Loewenthal, 1999). For both of these respondents, there is a confidence that Allah will listen to requests for help in their prayers and act upon them, and this knowledge seems to bring a sense of comfort. The second extract, from Muslim participant R9, also highlights a theme which occurred in the responses from other groups: the notion that prayer can be helpful because it presents an opportunity to off-load responsibility for dealing with one's troubles onto God. One danger with this kind of belief is what it implies those who are mentally ill have a choice about it; as another respondent Muslim R3 put it, '. . .good Muslims will not slip into deep depression', which implies that the mentally ill may therefore be perceived to be 'bad' Muslims; a primary example of community stigma over mental illness (Cinnirella and Loewenthal, 1999). Participants overall felt again that their Muslim faith held the answer—everything occurs due to 'God's will', which at least provides them the comfort of knowing that it is not meaningless- that one is suffering from mental illness for some (albeit spiritual) reason (Cinnirella and Loewenthal, 1999).

It may be easy to dismiss actor Tom Cruise's outbursts in 2005 against psychiatry as the ravings of an egomaniacal celebrity. The media certainly had a field day with Cruise, a fervent disciple of the Church of

Scientology, ever since he scolded actress Brooke Shields for taking prescribed medication to treat her postpartum depression and lectured Matt Lauer, host of the "Today" show, that psychiatry was a "pseudoscience" and antidepressant drugs were worthless because there is "no such thing as a chemical imbalance" (Mieszkowski, 2005) but he is merely an example of one of many people who have let religious influence effect their opinion of mental illness. But the Church of Scientology's war on psychiatry is no joke. For decades, Scientologists have maintained that the very notion of mental illness is a fraud (Mieszkowski, 2005). They base this belief on the views of Scientology founder L. Ron Hubbard, who proclaimed that psychiatry was an evil enterprise, a form of terrorism, and the cause of crime (Mieszkowski, 2005). Physicians, psychiatrists and scientists have consistently said that Scientology's approaches to mental health have no basis in medical fact and can be dangerous to people who may need treatment (Mieszkowski, 2005). In a 1969 article, "Today's Terrorism," published in a Scientology journal, Hubbard claimed that "the psychiatrist and his front groups operate straight out of the terrorist textbooks. The Mafia looks like a convention of Sunday school teachers compared to these terrorist groups." The psychiatrist, Hubbard went on, "kidnaps, tortures and murders without any slightest police interference or action by western security forces." Later, Hubbard wrote that, in society,

"there's only one remedy for crime -- get rid of the psychs! They are causing it!"

David Figueroa, president of the group's Florida chapter and a practicing Scientologist takes particular offense at the mention of attention-deficit disorder and attention-deficit-hyperactivity disorder. "Our contention from the very beginning is that these mental disorders are a scam," he says. "We know that there has never been any biological proof to any of these so-called mental illnesses these kids have been tagged with, whether it's ADD or ADHD. They don't exist. It's 100 percent fraud" (Mieszkowski, 2005). Many of the symptoms that kids exhibit in the classroom, Figueroa argues, may just be signs of academic, emotional or nutritional problems-difficulty understanding a lesson, parents who are getting divorced, an allergic reaction to a food such as peanuts or strawberries (Mieszkowski, 2005). In those cases, he suggests, a child needs only tutoring or vitamins. But he's convinced that psychiatrists don't recognize those possibilities; they just drug the child into submission. "Their only tool is to label and to drug," Figueroa says. "That's all they know how to do" (Mieszkowski, 2005). Hubbard designed Scientology to be the ultimate, if not only way, to address mental health problems. David Miscavige, the church's current leader, addressed the International Association of

Scientologists in Copenhagen in 1995 (Mieszkowski, 2005). He told the faithful that the church had two goals as the new millennium approached, dutifully noted by International Scientology News: "Objective one -place Scientology at the absolute center of society. Objective two- eliminate psychiatry in all its forms" (Mieszkowski, 2005).

Scientology claims to be the authority in the treatment of mental illness. Its desire to clear the planet of psychiatrists is public knowledge. But their own track record in the treatment of mentally ill people is alarming. There are numerous examples of a Scientology family devastated by the direct consequences of its faith.

Elli Perkins, a devout Scientologist and popular member of her community, treated her schizophrenic son Jeremy as recommended by L Ron Hubbard: by isolation and overdosing on vitamins. He stabbed her 77 times and then mercifully forgot what he had done (Exscn, 2008). In another case, Christa Martin, an ordained minister of Scientology, was instructed by the church that she should 'disconnect' from her daughter due to the fact that recommended Scientologist treatment was proving ineffective in her case (Exscn, 2008). Christa refused to do so as it would evidently leave her daughter, a mentally-ill teenager abandoned and without any hope of assistance and her non-compliance was cause for her

eviction from the church (Exscn, 2008). The Church is notorious for its mentally ill suicide rate, which far surpasses that of the mentally ill in the non-Scientologist population (Exscn, 2008), and this is at the direct fault of the religion's extreme perceptions of these illnesses and the treatment that is advocated within this religious practice (Exscn, 2008).

The Church of Scientology does not encourage people to eschew medical treatment entirely. They recognize that medical doctors should treat legitimate medical ailments, while Scientologists can address its spiritual causes (Beyer, 2010). However, they largely do not recognize psychiatric disorders as having physical roots. Instead, they view them as being entirely spiritual in nature (Beyer, 2010). Scientologists have deep concerns regarding treatments commonly prescribed by the psychiatric profession, especially psychotropic drugs, which sedate and alter the reality of patients to make them more docile and controllable without addressing the underlying conditions (Beyer, 2010). They are also against verbal therapy sessions where the therapist informs the patient what is supposedly wrong with him (Beyer, 2010). They think this is damaging to the patient and causes more harm when instead psychiatrists should be helping the patient discover for himself what underlying problems are

making them behave this way. Scientology considers that last concept the fundamental for true spiritual healing (Beyer, 2010).

As exemplified above in the case studies, religion plays a significant role. In Nigeria, mental illness is seen as the exhibition of evil spirits and as witchcraft- a practice backed by the Devil himself. The treatment commonly used- exorcism, also has strong religious links with the growing Christianity in the Nigerian community. In Nicaragua, mental illness is thought of being a manifestation of an out of balance spiritual self. Religion takes responsibility for playing a part in how mental illness is viewed, explained and treated in these cultures, as well as many others worldwide.

Every culture around the world has a perception of mental illness that is overall affected by the areas dominating religion. Religion adds another element to the mentally ill's struggle for acceptance, creating another hurdle for them to try and overcome.

Canada's Role:

In 1714 the "Hotel-Dieu" in Quebec provided a ward for women who were mentally ill and later took in about 12 men, but treatment of the mentally ill both in New France and British North America was primarily a

family responsibility, and patients who could not be cared for at home were placed in jails and poorhouses under deplorable conditions (Goodman, 2010). These conditions included overcrowding, poor sanitary conditions, inadequate food and heating, and no intervention or treatment (Goodman, 2010). The mentally ill, often caged or kept in barred rooms, were thought to be morally unfit and were treated essentially as sinners (Goodman, 2010). Asylums for the insane were opened in 1835 in Saint John New Brunswick, and in 1841 in Toronto and were essentially the first of their kind in the country (Goodman, 2010). For centuries, the practice was to send the mentally ill to faraway asylums or mental hospitals (Arboleda-Florez, 2005). As much as Canada prides itself on it's developed status, it is still a country that lives in fear of the unknown and is in favour of forced rehabilitation (Psychosurgery, 2009). In a detailed survey conducted by Canadian Medical Association in 2008, the actual magnitude of Canadian stigmatization was explored in these statistics: 46% believe that a diagnosis of mental illness is merely an "excuse for poor behaviour and personal failings", 10% think that people with mental illness could "just snap out of it if they wanted", 42% would no longer associate with a friend diagnosed with mental illness, 55% would not marry someone who suffered from mental illness, 25% are afraid of being around someone who suffers from serious mental illness, 50% would not tell friends or

coworkers that a family member was suffering from mental illness, 50% think alcoholism and drug addiction are not mental illnesses, 11% think depression is not a mental illness and 50% think that depression is not a serious condition. Mental illness has a huge impact on Canadian economy, the same survey discovered. A large majority of the population would not do business with people with mental illness. 58% would be unlikely to hire a lawyer with a mental illness, 58% would not use a child care worker with a mental illness, 58% would not hire a mentally ill financial advisor and 61% would not use a family doctor with a mental illness regardless of whether they could visibly recognize the disorder or not. Despite the country's liberal health care services and portrayed disposition as promoters of equality, mental illness, even in Canada, has become almost the last frontier of socially acceptable ignorance and discrimination.

Organizations Looking to Help:

NGOs and IGOs that work within a field of psychology often work with victims in distress from traumas such as Psychiatrists Without Borders, which is a non-profit organization that goes to developing countries to share education and aid for mental illness. They offer expert advice and training to clinicians in the community on how to provide basic

mental health care to individuals, groups, and families in need (PWB, 2011). They also organize lecture series, seminars, and supervision programs that are culturally sensitive and tailored to the needs and education levels of healthcare providers available in the community (PWB, 2011). But organizations such as this do little to internal stigmatization that is the most crippling to sufferers of mental illness. There are however a few systems in place to help with this irrational stigma and fear that also provide treatment, but they are more grassroots and subject to specific countries. An example of a system like this in Canada that battles the stigma of mental illness is the use of the mental health courts. A few provinces, such as Ontario and New Brunswick, have mental health courts already up and running (Moulton, 2007). Some provinces, like Newfoundland and Labrador, have ongoing pilot programs in place (Moulton, 2007). Now they are being joined by other jurisdictions looking for ways to decrease the criminalization of the mentally ill while at the same time decreasing the growing number of individuals cramming provincial and federal jails (Moulton, 2007). The primary objectives of the courts are to expeditiously assess and treat criminals who committed their crimes due to their mental illness (Schneider, 2007). The establishment of mental health care services throughout most of Canada has witnessed a steady decline, beginning with the de-institutionalization movement in the

latter half of the 20th century where much of the asylum population was sent to live in out patient facilities based upon good behavior instead of legitimate recovery (Schneider, 2007). As a result, a criminalization of mental illness has occurred as the mentally ill become increasingly more subject to accusations of malicious intent and criminal activity (Schneider, 2007). People with mental disorders accused of crimes deteriorate in detention centres and correctional facilities, where they receive a complete lack of much needed treatment (Schneider, 2007). A stigma is then placed on the mentally ill; an assumption that they are all "madmen" with intent to commit acts of felony. The desire of mental health courts is to identify persons whose mental illness and related lifestyle issues cause them to commit offences and to provide them with support, both to see them through the court process and to enable them to live lawfully in the community upon reintegration (Moulton, 2007). These organizations are attempting to eliminate the stigma associated with mentally ill criminals in North America and change people's perception on rehabilitation as opposed to jail time as a truer form of response to their crimes. They aim to teach that to incarcerate people merely because society failed to develop appropriate support, is a shameful approach to dealing with the unknown and overall the employment of these courts has been met with staggering support in surveys conducted (Moulton, 2007).

Conclusions

Solutions and Their Effectiveness

People who are mentally ill are just that- people, and when treated with dignity they respond in kind. There is no erasing stigmatization. Stigma will live on as long as humanity possesses the ability to pass on learnt behaviour. A vicious cycle is formed when attempting to ratify a global populations views on a subject- as many people who are preaching the necessity of integration, there will be an equal number of fearful people demanding seclusion of that which they do not understand fully. Solving these perceptions is a lot like solving racism, sexism or other forms of ignorant contempt- difficult to do because it is not necessarily possible to change everyone's outlooks. But ignorance is not tantamount with stupidity. Racism, sexism and homophobia are examples of issues where the stigma attached has been combated through exposure and education. The same must be done when assessing solutions for mental illness.

Education on what mental illness is and what is required. People with mental illness and those who feel passionate about the respect all humans deserve the right to should make known publicly their struggle and their hopes. Speakers from the black, gay and feminist communities have spread their messages and rallied support. Many societies may not see what they are doing as wrong and will only realize the difference when the issue is laid on the table and talked about. It is necessary to sensitize the public to the problems of stigma and create an environment open for discussion and the abolishment of fear. When there is an atmosphere conducive to dialogue between key players and the public, change will be possible and that atmosphere can only be created through education and exposure to the issue. This must be done to ensure a sound quality of life can be provided to all citizens of the world.

The solutions for the case studies previously reviewed are shown to not be working at the highest efficiency, except in the case of Nicaragua. In Nigeria, exorcism is a strict violation of human rites and in the end does nothing but put the country in a constant state of fear. China's solution of ignoring the illness has not worked and proof of this lies in the violent crimes committed by the Chinese citizens who do not receive appropriate care. In a religious aspect, mental illness needs to be discussed without religious teachings being involved. Blaming a holy deity does nothing to

cure the sufferer nor reduce harsh stigma. Also in the case of Scientology which uses introspection and vitamins as means of solving mental illness when infact the horizons of thought need to be expanded and explored- if something has been proven numerous times to be unhelpful, a new solution should be attempted regardless of how entrenched the religious values are. Solving this issue becomes a question of global human rites, not just a series of failed attempts claiming to be the right way to do things. None of these places and cultures see much wrong with their methods and haven't changed in years. But change is possible, and that is something that has been shown in the past as well.

Like each prejudice that has been combated before it, perception of mental illness becomes something that global society must become united on and realize that exclusion based on something that is genetically manifested, is a type of malice that should be unacceptable in a society that strives for the "global community" and the inclusion and influence of all.

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