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Research Paper

Effect of Stigma & Shame on Attitudes of Young Adults as Well as Older Adults Towards Mental Health

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ABSTRACT

Aim **-** The aim of this paper is to study the attitudes of young adults and older adults towards mental health in respect to the stigma shame. For the study two tools, Perceived Discrimination and Devaluation Scale and Attitude Towards Mental Health Problem Scale were used. ***Sample*** **-**The sample comprised of 102 adults; sample consists of 51 young adults in the age range of 18-45 years and 51 older adults in the age range of 46- above. The sample had both males and females (40 and 62 respectively) collected through random sampling. ***Result*** **-** Results show weak yet significant relationship between attitude, stigma and shame. the results also show a significant difference in perceived stigma of the young adults as well as older adults where (M= 3.33, SD =.683) & (M= 2.98, SD= .374) respectively, so we can infer that young adult have a higher perceived stigma than older adults. As we saw above stigma and attitude have a negative correlation, thus we can say that the higher the stigma in young adults, the negative the attitude towards mental health and vice-versa for the older adult's population. The 2nd hypothesis and the 3rd hypothesis suggested that stigma, shame and attitude would show a high correlation and that young adults would have a low level of stigma and shame, then older adults, both of which we were unable to establish. A more in-depth study at a larger scale needs to be conducted to provide more conclusive evidence.

Keywords: *Stigma, Shame, Attitudes, Mental Health*

Mental Health

According to WHO – Mental Health is not only just the absence of illness but a state where there is social, physical as well as mental well-being in which a person realizes their own capabilities and then can cope up from stressful life situations as well as work productively and make contributions towards their communities.

According to American Psychiatric Association- Mental Illness is a health predicament that involves change in thoughts, emotions and behaviour, associated with problems with social, occupational or family functioning.

As any country develops and grows, life becomes much more complex and the problems relating 0to cultural, social and economic changes continues to rise. India is one of the fast-

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developing countries, with the growing population, economy etc., there is a fast-paced changes, High tension and stress that the society faces at work, school, etc., unhealthy lifestyles as well as stress both leads to mental health problems.

WHO states that "without Health there is no Development and no health without Mental Health."

According to WHO – about 450 million people in the entire world are suffering from mental health and behavioural disorders nearly 1 million of these people commit suicide.

WHO reports regarding India's current scenarios states that India's mental health support is inadequate due to the tremendous shortage of psychiatrists, psychologists and the whole mental health care support team in the country, compared to the number of individuals suffering from mental health issues. The number of personnel in India approximately are psychiatrists (0.3), psychologists (0.07) nurses (0.12) and social workers (0.07), while the desirable number per patient should be above 3 psychiatrist and psychologist per 1,00,000 patients.

WHO also infers that about 7.5% Indians suffer from some mental health issues and disorders and proclaim that by end of this year roughly 20 per cent of India's citizen will suffer from mental illnesses. According to the numbers, 5 Crore Indians will be suffering from depression and another 3 Crore Indian's will be suffering from anxiety disorders.

India accounts for approximately 36.6 per cent of suicides that happen globally, and that the suicide rate has surpassed the maternal mortality, presently the leading death rate is seen to be amongst women and teenage girls aged 15-19 years. Lancet studies announces that India's contribution to global suicide deaths has increased from 25·3% in 1990's to 36·6% in 2016 among women, and from 18·7% to 24·3% among men. As per the (NIMHANS) National Mental Health Survey in 2015-16, conducted by the National Institute of Mental Health & Neurosciences Bengaluru, under the department of the Union Ministry of Health and Family Welfare, the reports revealed that 9 crore teenagers in the age group 13-17 years old suffer from depression and other mental health disorders and are "in need of active intervention". Whereas, according to a study by Lancet, suicide deaths ranked first among all the causes of death in women aged 15-29 years in 26 states, and in women aged 15-39 years in 24 states.

According to World Health Organization WHO, the weight of mental health problems and the issues is of the tune of 2,443 disability-adjusted life years per 1,00,000 population, and the age-adjusted suicide rate per 1,00,000 population is 21.1. According to the burden of mental disorders across the many states of India: The Global Burden of Disease Study in 1990–2017 reports – 1 in 7 Indians were affected by mental disorders of unequal severity in 2017 and the corresponding contribution of the mental health disorders to the total disease burden in India has almost doubled since the 1990's.

When it comes to an individual's physical health, people seem to be so conscious and aware these days – they also have access to a lot more things and services to maintain their health, they seem to know everything about superfoods, the latest diet trends or workouts routines, but yet when it comes to mental health, the awareness just isn't there. So many people

themselves aren't even aware that they may be suffering from a form of mental health issues and these statistics show the harsh reality.

Mental health as well as mental wellbeing leads to happiness and having a meaningful and satisfactory life. Mental health affects not only how we think but also how we feel, and act. It also helps in determining how we handle stress, related to others and oneself and make choices. Mental health is important at every stage of life, from a persons childhood and adolescence through adulthood.

Mental health is essential for our individual and collective ability as human beings to think, effuse, interact with each other, earn a living and enjoy one's life. On this basis, the advancement, the protection and rehabilitation of one's mental health can be regarded as a vital concern of the individuals, the communities and the societies throughout the world.

Mental Health Problems can affect one's thinking, mood, and behavior. Multiple social, biological, and psychological aspects determine the level of mental health of people at any point of time. For example, biological risk factors, such as one's genes or brain chemistry, history of mental health problems in family, one's Life experiences such as trauma or abuse suffered, violence and relentless socio-economic pressures are some of the prominent risks to the mental health of a person, e.g.- sexual violence. Also, there are specific psychological and personality factors that make people vulnerable to mental health p problems.

Poor mental health is also seen to be interconnected with rapid social change, stressful work life situation, social exclusion, gender discrimination, an unhealthy lifestyle, physical ill-health and human rights violations.

In the recent years there have been several studies aimed at mental health promotion and prevention programs for school children, office workers, medical staffs, patients – their families and the other general population of India. There have been several obstacles in the way of improvement of mental health of patients as well as spreading the awareness about mental health. The concept of mental health has many implications in different domains of life like- religion, politics, policies, personal as well as social life etc. The most troubling feature of psychiatric diagnosis and practice is STIGMA (Dr. Thirunavurakasu, 2011).

Stigma is seen as a mark of disgrace towards a person, subject etc. the person with mental illness is labelled by their illness are here seen as the part of the stereotyped group. There are negative beliefs and attitudes towards this group which creates prejudice leading to discrimination.

Stigma

The World Health Organization states that – "the single and most important barrier that we need to overcome in the community is Stigma and the associated discrimination towards the person suffering from mental and behavioural disorders. "Stigma is a Greek work meaning mark or tattoo that was burned or cut into the skin if slaves or traitors to be able to identify them as blemished. Stigmas relating to culture, race, ethnicity, gender, intelligence, body, health etc. People who are stigmatized usually feel different from others and often feel de-valued and ashamed. Stigma may affect the way the those who are stigmatized behaves. These individuals often start acting the way those who are stigmatize want them to. It also

starts shaping their emotions and beliefs, they start losing their social identity as well as their self-esteem.

Studies indicate that by the time children reach 10-year-old, they start being aware of the cultural stereotypes towards different groups in the society.

Erving Goffman one of the most influential sociologists of the twentieth century gave the theory of Social Stigma. He defined stigma as a feature, behaviour, or reputation which is socially disapproved in a certain way. It causes a person to be categorized by others as undesirable, rejected stereotyped rather than a accepted in a normal way. Goffman described stigma as a space between actual social identity and virtual social identity.

Gerhard Falk defines stigma based on two categories – achieved stigma and existential stigma. He says that existential stigma is the stigma which the person has no control over or he did nothing to earn such stigma. On the other hand, achieved stigma is the stigma where the person has maybe conducted in such way that the stigma is earned. Gerhard says that we the society will always stigmatize on the basis of behaviour or condition because in doing so leads to one's group solidarity and helps setting out insiders from outsiders.

Stigma worsens the condition of a person's illness and also becomes a barrier towards psychological help seeking behaviour. It is not only the person with mental illness who is affected by stigma but also their families who are affected these leads non-disclosure of the illness as well as giving no support to the patient. These people then as a result of stigma and taboo towards mental health view the mental health professionals as corrupt or evils and view the psychological treatment as suspicious.

The influence of stigma is twofold -one is public stigma it is the reaction that the general population has people with mental disorders Second is self-stigma which is the prejudice because of which people with mental disorders turn against themselves.

Both public as well as self-stigma is can be understood in that terms of the 3 components-stereotypes, discrimination and prejudice.

WHO says that one in every 4 families has at least 1 member suffering with mental disorder. It is not only the health and the social costs that they have to pay those who are suffering from mental disorders are also the victims of stigma, violation of human rights as well as discrimination. It is now well discerned that 70% of the people suffering with mental health disorders do not seek help.it has also been discussed that help seeking can be improved with better acceptance and classifying of mental disorders, with the increase in understanding of causes and the treatments for mental health issues, reduction in stigmas and the belief in the treatment approaches and the methods used. (Jorm.A.F & Barney.L.J 1997) (Fogel .J. & Houstan.T.K. 2006).

Unfortunately, stigma surrounding mental health is still very common. stigma is not just limited to mental health conditions, but also to the attitudes towards psychiatric illnesses and issues tend to be more negative than those toward medical conditions.

Research shows that stigma is 1 of the leading risk factors resulting in poor mental health. Stigma causes delays in treatments. It also lowers the opportunities of a person with mental illness to receive appropriate and adequate care willingly.

To some degree Stigma does influences societies view on mental health irrespective of age, gender etc.

Depression and psychosis are often seen to have an onset during adolescents and early adulthood. (Conus.P. & Lambert.M. 2000). The rate of mental and behavioral disorders is 20-27 % in youths. (Burns.J.R. & Rapee.R.M. 2005), and. This suggests that this age group is an important mark to raise awareness and knowledge of mental health. the older population is seen to have even less mental health literacy than the youth. The earlier studies reveal that youths do not have a good mental health literacy; these studies reveal that approximately 50% people aged 12-25 were able to identify depression and only a quarter were able to identify psychosis correctly. (Harris.M.G., Jorm.A.F & McGorry.P.D. 2006).

"Mental illness has always been viewed as a sign of shame and weakness in our society. Despite how much we have progressed and discovered about how our brain works in the last 50 + years, stigma still persists," (Marina Olson 2017).

Shame

Shame is a very powerful negative emotion, which is associated with many of the mental disorders, it can be both an etiological factor as well as a consequence affecting symptom, a psychological defense and a therapeutic outcome. (Jessica.Y. 2018)

The present shame theorists and the empirical researchers suggest that shame can be called as a self-conscious emotion (M. Lewis, 1992), because it mainly associated with an evaluation of the self. Shame is believed to be vulnerable emotion that is associated by the feeling of being inferior, small, and of less than others. The self, as a whole, is underrated and considered to be unsatisfactory, inept, and inferior.

Shame might also include the feeling of being feeble, reproach, and scorned (Mashek, Tangney&, Stuewig, 2007, Hassel, Rugset, Vikan, Johansen, & Moen, 2010).

Gilbert (1998) gave a subtype to shame – internal shame as well as external shame. He explains that internal shame is the one that originates from within oneself, it can be negative self-evaluation or self-generated criticism. External shame on the other hand is the shame that originates from outside oneself, it can be the upsetting awareness that others view them negatively.

Shame is one of the most complex emotions and is often discussed with a lot of reluctance; these feelings are usually vulnerable and unbearable.

Shame seems to be present in a wide variety of the psychological disorders, it is also associated with mental health issues like social phobia, eating disorders, depression etc.

There is an urgent need to change the attitudes of people towards mental health and its services to increase the help seeking behavior and decrease the behavior, attitude as well as

beliefs formed as a result of stigma and shame and for that we need to know how exactly stigma effects people their thoughts, emotions attitudes, beliefs etc.

Attitude

Attitude refers to a set of beliefs, emotions as well as behaviors one has towards any object, event, person or thing. They are often a result of our upbringing as well as our experiences of the world around us. It is the way we see things and interpret the meaning accordingly. Carl Jung defines attitude as "the preparedness of the psyche to act and react a certain way". The study of attitude formation studies how one forms an evaluation of people, places, events, etc. it says that theories such as instrumental conditioning, classical conditioning and social learning are mainly accountable for development of attitude. It can change as a person's experience unlike ones personality. (Doob 1947)

There are 3 components of attitudes known as CAB or the ABC's of attitude.
1-Cognitive Component: ones thoughts and their beliefs about the subject
2-Affective Component: How the object, the person, the issue, or the event makes one feels
3-Behavioral Component: How the attitude influences ones behaviour.

There are various of factors that can influence how and why the attitudes formation takes place like

- Environment- can be a result of an observation or a personal experience.
- Social factors- social norms and rules affect the influence ones attitude
- Learning - attitudes can be learnt in a variety of ways
- Conditioning – operant conditioning through reward and punishments.
- Observation- observing people around them

Zajonc through research showed that people are likely to hold a positive attitude on the attitude objects when the people are exposed to it more frequently to than if they were not. Louis Leon Thurstone in 1928 proposed whether one can measure attitude. Over the course of years many scales have emerged which can be used to assess attitude like Likert scale, Guttman scale etc.

Some Theories of the attitude change and formation.
a- *Functionalist theory*. Daniel Katz gave a functionalist theory of the attitudes. He says that the attitudes are regulate by the functions as they serve for one. Individuals hold the given attitudes as these attitudes are the ones that help one achieve ones basic goals.
b- *Learning Theory*. the Classical conditioning, the observational learning and the operant conditioning, can be used to bring an attitude change.
c- *Cognitive dissonance theory* – this theory stresses on attitude change - and that the behaviors can govern the attitudes.

Studies show that attitudes change over time as people age, as well as that it has a direct result on one's behaviour. It is very informative to know how peoples attitude change over the course of life. to know how attitude may vary between the young and the old and how each one views mental health and its care. To know the way ones attitude is. If we know the current thoughts attitudes and Beliefs of different age groups towards mental health, disorders and treatments, we can use this knowledge in clinical as well as general population

to spread proper awareness, knowledge and practices where it is lacking, to give people the proper solutions to each of their own distinct need.

Progress of mental health awareness, care and services has been slow in the developing countries. The government has other public health priorities than mental health services so the attention, trained professionals, infrastructure, human resources and appropriate funding is not received in this area for it to flourish.

Young Adults

Young adulthood is a adjustment period where ethical values instilled in childhood are associated with ethical values ingrained in life from adolescent to adulthood (Özbay, 1997). Young adulthood is the period of synchronous changes in all aspects of one's lives. (Schulenberg, 2004).

Young adulthood comes with a lot of changes, new rules and responsibilities. It is a phase in life where young adults go on to pursue a higher education, look for more jobs, some starts on new ventures, get married and go abroad for future prospects.

WHO classifies 'Adolescents' as people in 10-19 years age group and 'Youth' as 15–24-year age group. While 'Young People' covers the age group 10-24 years.

There are about 350 million adolescents incorporating about 22% of the total population in countries of the South-East Asia Region (SEAR). Adolescents are not a homogenous population. they exist in a various circumstance and have very diverse needs. The transition from childhood to adulthood involves physical, psychological, sexual and social developmental changes, all taking place at the same time. Also, opportunities for development through this transition poses risks to their health and well-being.

Older Adults

Old age refers to an age are nearing or surpassing the life expectancy of a normal human being, and which signifies the end of human life cycle.

The word *old*, is associated with deterioration and agedness, but it doesn't seem to capture the many different arcs a human life can trace after their middle age.

According to the Oxford English Dictionary, the middle age is " one's period of life between young adulthood and old age, now t is usually regarded as something between forty-five and sixty".

Ina Jaffe says, "Older adults now seems to have the most diverse life experiences of any other age group".

Old age is not just a definite biological state, the chronological age described as "old age" differs culturally and historically around the world.

WHO says that the prevalence of mental disorders and illnesses and the people treated for it is found as 77%-85% in the less developed countries.

WHO says that suicide is the leading cause of death among the people aged between 15-25. Seeing the global shift and advancement in every sector of life as well as the thought process of the new generation, it is time we lead our society to betterment and to a mentally healthy and fit society for this we start by spreading awareness amongst not only the youth but also the older generation.

So, in the present study we aim to better understand and find out the current scenario of the Effect of Stigma, Shame and Attitudes of young adults as well as older adults towards mental health.

REVIEW OF LITERATURE

Kanika.K.A.et.al (2017) -: objective here was to find the effectiveness of an intervention-based programme designed to create more positive attitude towards people with mental illness among the college students in Delhi. Sample consisted of 50 students. The Results showed increase in the feelings of kindness, ideas of community mental health, less feelings of authoritarianism, reduced social restriction, less labelling after the intervention and greater acceptance of needs.

Joana. M.C. (2016) -: with the help of Attitudes Towards Mental Health Problems Scale (ATMHP) is a self-report scale Joana and associates tried to assess the attitude of Portuguese population towards mental health and its factors as well as try to adapt this scale to this population the sample consists of sample size of 411 individuals aged from the (19-81). Confirmatory factor analysis was done and the results showed poor adjustment. It showed further study is to be done.

Gabriella.V.et.al (2015) -: tried to find out the association or the effects of shame with the various mental and behavioural disorders. Results showed that shame leads to a very excessive emotional state with a very negative self-esteem, however shame has never been applied or used as a diagnostic criterion in any of the DSM.

Raymond.J.G.et.al. (2015) -: tried to examine the gender difference in mental health literacy. Sample size 373 participants male and female34-87 years old. Females were seen to have better mental health literacy skills than males.

Sushmita. et .al (2015)-: tried to find out the attitudes and stigma among post graduate physicians of India towards people with psychiatric illness. Results showed that participants had negative view towards people with schizophrenia, but overall, they had positive view on mental health.

Aseel.H.et.al. (2014) -: tried to find out mental health literacy of people living in non-western – countries through a review of literature. Sample consisted of 3 groups- general public, students and young people. results showed that countries like these have some well researched disorders like schizophrenia, depression etc, but other disorders are not as extensively researched. people were able to recognize the popular disorders So more research is recommended.

Marie. B.H.et. al (2014) -: tried to find out through a survey the properties of stigmatizing attitudes of people towards mental disorders. The aim here was to make the structure of stigma clearer so 2 categories of samples were taken one the general community 15+ people

and another's youths ages 15-25. Results through new exploratory structural equation modelling (ESEM) methods showed that structure of stigma attitudes in young persons and adult people is close in personal held attitudes and that which is perceived in others.

Namkee G.(2014)-: tried to study age group differences and correlation of treatment use and the perceived treatment need of the substance use disorders and mental health problems. The 65+ age group of people was the least likely to use treatment group and the perceive treatment need, but the 50–64 age group was much more similar to the younger age groups people. the 65+ age group lack of readiness to stop the usage of and the cost/limited insurance were the most frequent barriers to substance use disorders and Mental health treatments respectively, among older adults, and these people were less likely than the younger age groups to report the stigma/confidentiality concerns for the Mental Health treatment.

Robb.C. et. al. ()-: tried to find out the Similarities and differences among the attitudes of younger and older adults towards mental health care. Using surveys responses of 474 older adults ranging 65 and above were juxtaposed with data from national survey of 1001 people 21- 65 years old. The results showed many similarities in attitudes like-severe mental disorders treatment, mental health care importance, cost and coverage issues to care. Some of the difference in attitudes like –conception about less severe mental disorders, policy, sources of referrals, use of mental health facilities.

Reynders.A.(2013)-: tried to find out the relationship between help seeking behaviours and attitude and stigma. A total of 2999 Dutch and Flemish participants between 18 and 65 years responded. Scales used were Attitudes toward help seeking, perceived stigma, self-stigma, shame and intention to seek help. The Population in Netherlands, have a low suicide rate, is seen to have a more positive attitude toward the help seeking attitude and experience a less self-stigma and shame compared to people in the Flanders, where suicide rates are relatively higher.

Claire.H.et.al (2013) -: tried to find out how stigma towards mental health effects the help seeking behaviour of people. Results showed that more than 70% people old and young who has mental illness does not receive proper treatment form the proper heath care workers.

Aseel. H. et.al. (2012)-: tried to find out the factors that are affecting the Arab population living in UK from (ATSPPH) Attitude Towards Seeking Professional Psychological Help. Results showed that Arabs have a comparatively less positive ATSPPH as they showed strong belief in the supernatural a lower belief in the western physiology.

James. D. L. et. at. (2012) - : tried to find out campaign evaluation of young people to find out its impact on their awareness and attitude towards mental health. Two samples were taken, they used online questionnaire format to collect data before as well as after the campaign. Results showed that the participant who attended were more likely to talk and seek help for the problems relating to mental health.

Georgina.G.et.al. (2011) -: tried to compare and find out the attitudes of professionals working in mental health area and other professionals working in different medical areas towards mental disorders. Results showed that there was a general positive attitude towards people suffering from mental disorders in both the groups. People in other medical areas

considered them to be dangerous than people in mental health work areas. No remarkable difference in emotional empathy.

Rajiv.S.et.al. (2011) -: tried to find out the rate and factors leading to attitudes towards seeking professional psychological help (ATSPPH), amongst south Asian population. Results showed that women were more likely to have more ATSPPH than men. it was also seen that ATSPPH depended on the persons gender, ethnicity, values, cultural mistrust and ethnic identity.

Rana. W. et. al (2011) -: tried to assess the attitude of older Australian people towards psychological treatment. results showed that this populations attitude towards seeking help in this area was comparatively positive also showed that more than half of the population have had sought for psychological help.

Alison. L.C.et .al (2010) -: tried find out the stigmas of depression perceived and personal depression stigmas as well as its predictors amongst adolescents of Australia. Sample size of 1375 (12-17) years old adolescents were taken. Results suggested that level of perceived stigmas were much higher than personal depression stigma.

Kyaien.O.C.et.al (2010) -: tried to see the effect of race and stigma on the help seeking among the older adults with depression. Sample size (248), Aged 60+ older people. Results showed that older people with depression have a very high level of public stigma due to which they are more likely to not seek for treatment.

Sakellari. E. et .al (2010) -: tried to find out through a review of literature on intervention in secondary education aiming to influence students attitudes towards mental health. Results indicated that this education intervention has a positive impact on children's attitude towards mental health, increases knowledge about mental health. Also indicates we need more studies on this topic.

Christoph.L. et.al. (2009) -: tried to assess the stigmas that people have towards individuals with mental illnesses in developing Asian countries. results reveal that stigmatization towards individuals with mental illness is omnipresent in Asian countries. People with mental illnesses are seen as aggressive and dangerous. people try to keep a distance from such people. Religion is another maintaining factor of discrimination and stigmas.

Sheikh.S.et.al. -: Tried to examine and asses the relationship among ones cultural casual beliefs about the reasons of mental distress and the attitudes which is related to seeking professional for mental problems. Results showed that culturally decided casual beliefs that are of mental distress leads to an attitude towards seeking of professional help for Asians.

Faye.A.G. et. al. (2009) -; tried to find out and assess stigma and discrimination some of the barriers people have and face towards mental health care among 4 ethnic minorities in America. Results showed that because of the discrimination and prejudice faced by these people for them being in minority and when faced with the weight of mental problems, this leads to double stigma an impede their treatment and well-being.

Kathryn. M. Q. et.al. (2009) -: tried to find out the attitude of older people towards mental health and illness. Results showed that older people also have a range of positive and

negative attitudes towards mental illness like the younger population. Those who had negative perception to mental illness was seen to have a negative attitude towards the ageing.

Louise.F. et al. (2008) -: tried to find out individuals belief and knowledge towards mental health problems, its risk factors, treatments, help and their variations according to age. the differences in the older and younger age groups were seen such as – effectivity of the treatment, helpfulness of certain treatment workers, the older adults more likely believe that the cause of schizophrenia is weak character. While the younger adults is more keen in over identifying depression signals.

Anderson. M. et. At. (2007) -: tried to find out the attitudes of nurses and doctors towards those who are working with youngsters and children who self-harm. The Suicide Opinion Questionnaire was used to collect data. Sample included 179 nurses and doctors from 3 clinics areas – emergency, pediatric and adolescent mental health services. Results showed that the doctors and nurses agreed on certain scales like – cry for help, impulsivity, right to die, normality, mental illness and aggression scales. While they had less unity on- moral evil and religion scales. There was no significant difference on some scales such as – age, experience in current post and sex.

Claire. M.K. et.al. (2007) -: tried to research and see how intervention in early life to improve mental health literacy can help promote early intervention in mental health. The results showed that early intervention is effective with the use of specific health promotion model to facilitate their development.

Yuri. J. et.al. (2007) -: tried to find out Korean American adults of different age groups attitude towards mental health services. Sample size consisted of a younger population aged- (20-45) and an older population aged- (60- and older). The mean level assessment showed- that older and younger population have similar level of positive belief and attitude towards mental health. Findings showed that the older population are more influenced cultural stigmas and misconception and can also influence negativity towards their use of services.

Ranjana. M. et.al. (2007)-: researched on the cultural differences among Asian and non-Asian female students in shame focused attitude towards mental health. 'Attitudes Towards Mental Health Problems' (ATMHP) self-report scale was used to study external, reflected as well as internal shame. Results showed that Asian students had higher reflected and external shame but did not have beliefs of internal shame.

Mackenzie.C.S.et.al (2007) -: tried to find out age and gender differences in help seeking attitude towards mental health problems. results showed that men had more negative attitude to mental problems openness, due to under application and use of psychological services. Older females have more positive attitude in help seeking behavior.

Paul.G. et. al. (2006) -: tried to find out the effect of shame, subservience and confinement towards mental health and services in South Asian women. Results showed that for these women maintaining and keeping family honour is connected to personal shame. . loss of this honour was one of the very foremost reasons for south Asian women not reaching out for help from mental health services.

Anita. C.et.al (2005) -: tried to find the occurrence of stigmas towards mental health in teens and their willingness to use these services. Used written questionnaire and a sample size of 274 8 the grader. results indicate presence of stigmas in early adolescents and their negative attitude and willingness to use the services. Girls than boys were twice likely to report willingness to use mental health services as girls have higher mental health knowledge and higher rate of acceptance of problems.

Friederick.E.M. et. al. (2005)-: tried to find out adolescents attitude towards people with serious mental illness. Results suggested that adolescents viewed people with mental illness as more out of control, aggressive and violent.

Michael. G. et.al (2005)-: tried to find out how the impact of clerkship in psychiatry, changes the attitudes of Nursing students towards mental illness and psychiatric case recognition. Cohen and Struening's Opinions about Mental Illness (OMI) scale, was used to measure 92 students of semester 7 School of Nursing of Athens University, attitude towards mental health illness before as well as after the clerkship. After the training it was seen that some students viewed opinions like – less sense of authority and biased beliefs. Others expressed negative views in four/ five of OMI scale factors.

Vanessa.P. et.al. (2005) – tried to find out the effect of mental health awareness campaign in UK and Canada schools. sample age – 14-16 aged students. The results showed that short awareness programs are effective in bringing about positive attitude towards mental illness in children.

Rationale of the Study

Mental health is an important aspect of everyone's life and most often overlooked and thought as insignificant. With the stigma, shame as well as the discrimination associated to it, it is most often than not seen in a negative light. 21st century the era of awareness to the minds of common people be it young or old, everyone has heard about it at least more than once in their lives. The importance of this study rings with the awareness in young as well as older population and to see how different their views are. The reason of this study corresponds with the ability to handle the clients of various age groups. The reason of conducting this study is to be able to find out how different are the attitudes of the young adults as well as the older adults towards mental health. To find the positive effect of the awareness towards mental health, as well as the mentality both the age groups have when approaching for help. Also, this study would help, determine the levels of stigma and shame in both the age groups and would help in providing appropriate intervention to reduce the negativity associated with mental health

METHODOLOGY

Aim

The aim of this study is to find out the effect of stigma & shame on the attitude towards mental health.

Objective

- To assess the correlation between stigma, shame and attitude.
- To find out if the attitude towards mental illness differs between young adults & older adults?

- To determine the levels of stigma, shame and attitude in young adults as well as older adults towards mental health.

Hypothesis

- There is a high correlation between shame, stigma an attitude.
- Young adults would have a below average level of stigma an shame, than older adults.
- There exists a difference in the attitudes of young adults and older adults.

Design

Quantitative analysis was computed for the purpose of the study. Without manipulation the variables it helped to assess the relationship between them.

- Independent variables
- Stigma
- Shame
- Dependent variable
- Attitude
- Sample

For the purpose of the study young adults and older adults were selected. The sample comprised of 102 adults; sample consists of 51 young adults in the age range of 18-45 years and 51 older adults in the age range of 46- above. The sample had both males and females (40 and 62 respectively) through random sampling.

Description of tools

For the study two tools, Perceived Discrimination and Devaluation Scale and Attitude Towards Mental Health Problem Scale were used.

Perceived Discrimination and Devaluation Scale

perceived stigma was measured by using the perceived devaluation and discrimination scale (PDD). This scale is a 12-item tool which measures the extent to which an individual believes that most people will devalue or discriminate against someone with a mental illness. this was measured on a 4-point Likert scale with the possible scores ranging from 1 to 4 agreement scale (1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree), so that a higher score indicates a higher level of the perceived stigma. This scale has been widely used across the world. Items 1, 2, 3, 4, 8, and 10 were reverse-scored.

Attitude Towards Mental Health Problem Scale

ATMHP is a 35-item scale used to find different aspects of shame in relationship to a mental health problem.

ATMHP is a self-report scale aimed at assessment of attitudes toward mental health that involves various factors relating to the attitudes and shame (internal, external, and reflected shame) when facing the mental health problems. This scale is divided into five sections

- Section 1 - A person's perception of how their community sees mental health problems (items 1–4) and A person's perception of how their family perceives mental health problems (items 5–8).

- Section 2 - A person's perception of how their community would see them if they had a mental health problem (items 9–13) and A person's perception of how their family would see them if they had a mental health problem (items 14–18).
- Section 3 - focuses on internal shame and the negative self-evaluation of having a mental health problem (items 19–23).
- Section 4 - focuses on reflected shame and beliefs about how one's family would be seen if one had a mental health problem (items 24–30).
- Section 5 - looks at fears of reflected shame on self, associated with a close relative having a mental health problem (items 31–35). All items are scored on a 4-point Likert scale ranging from 'Do not agree at all'=0 to 'completely agree'=3.

Procedure

To study the effect of shame and stigma on the attitude towards mental health. The sample were selected and finalised. The previous literatures were thoroughly viewed and cited and the appropriate tools for the study were selected and finalized after verifying their validity with the present study. Objectives and hypothesis were formed further. The data collection was done online through Google forms by random sampling. The sample included 50 young adults and 50 older adults and all the necessary information was given and confidentiality of the test and responses were also ensured. Participation in the study was voluntary and participants were appreciated for their time and efforts. The scores were transferred to the excel sheets and the total scores were then calculated. Then further the analysis for the objectives of the study was computed through SPSS version 21.

Statistical Analysis

For the analysis of the scores SPSS version 21 was used. To assess the correlation between Stigma, Shame and Attitude bivariate correlation was done. Descriptive statistics was done to determine the levels of stigma, shame and attitudes among young adults and older adults and to evaluate the difference in the attitudes of the young adults and the older adults towards Mental Health independent samples T test.

RESULTS & FINDINGS

The analysis for the results of the study was done through SPSS version 21. The statistical methods used for the analysis are descriptive statistics, correlation and T test.

Table 1- Descriptive Statistics- Gender

Gender					
		Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid		3	2.9	2.9	2.9
	1-Female	62	57.7	57.7	60.6
	2-Male	40	39.4	39.4	100.0
	Total	102	100.0	100.0	

The gender descriptive shows that the number of females that participated in the study accounts for -57.7%, and males account for a total of 39.4% of the total 100.0% population. No other gender description has been seen in the study.

Scale I– perceived stigma scale

Scale II – attitude towards mental health problem scale -:
Section 1- individuals perception on how their community and family perceives mental health problems.
Section 2- how their community and family see them if they had mental health problems.
Section 3- internal shame and negative evaluation of suffering from mental health problems.
Section 4- reflected shame and belief about how the family would be seen if any member had a mental health problem.
Section 5- fears of reflected shame on self, associated with one's close friend or relative going through mental health problems.

Table 2- Mean & Standard Deviation- Age

Group Statistics					
	Age Group	**N**	**Mean**	**Std. Deviation**	**Std. Error Mean**
Scale I	18-45	51	3.33	.683	.096
	46-above	51	2.98	.374	.052
Scale II Section 1	18-45	51	10.53	5.547	.777
	46-above	51	9.49	4.096	.574
Section 2	18- 45	51	3.92	5.359	.750
	46-above	51	8.67	6.137	.859
Section 3	18-45	51	4.69	4.193	.587
	46-above	51	4.74	4.337	.613
Section 4	18- 45	51	6.73	4.988	.699
	46-above	51	5.46	4.908	.694
Section 5	18- 45	51	4.62	4.633	.655
	46-above	51	3.34	3.293	.466

(YOUNG ADULTS – 18-45), (OLDER ADULTS – 46-above)

The descriptive statistics results showed that (see table 1) Young Adults denoted as 18-45 age and Older Adults denoted as 46- above of attitude in Scale I - (M= 3.33, SD =.683) & (M= 2.98, SD= .374) respectively. In Scale II – Section 1 (M= 10.93, SD= 5.547)& (M= 9.49, SD= 4.0), Section 2 (M= 3.92, SD=5.3) & (M=8.67 ,SD= 6.1), Section 3 (M= 4.69 ,SD= 4.1) & (M= 4.7, SD=4.3), Section 4 (M= 6.7, SD= 4.9) & (M= 5.4, SD=4.9) and Section 5 (M= 4.6, SD= 4.6) & (M=3.3, SD= 3.2) respectively.

Table 3 – Population Sample T Test

Independent Samples Test										
		Levene's Test for Equality of Variances		**t-test for Equality of Means**						
		F	**Sig.**	**T**	**Df**	**Sig. (2-tailed)**	**Mean Difference**	**Std. Error Difference**	**95% Confidence Interval of the Difference**	
									Lower	**Upper**
Scale I	Equal variances assumed	22.908	.000	3.237	100	.002	.353	.109	.137	.569
	Equal variances not assumed			3.237	77.459	.002	.353	.109	.136	.570
Scale II section 1	Equal variances assumed	5.868	.017	1.076	100	.284	1.039	.966	-.876	2.955
	Equal			1.076	92.023	.285	1.039	.966	-.878	2.957

	variances not assumed									
Section 2	Equal variances assumed	4.986	.028	-4.159	100	.000	-4.745	1.141	-7.009	-2.482
	Equal variances not assumed			-4.159	98.213	.000	-4.745	1.141	-7.009	-2.481
Section 3	Equal variances assumed	1.404	.239	-.063	99	.950	-.054	.849	-1.738	1.630
	Equal variances not assumed			-.063	98.715	.950	-.054	.849	-1.738	1.631
Section 4	Equal variances assumed	.038	.845	1.285	99	.202	1.265	.985	-.689	3.220
	Equal variances not assumed			1.285	98.999	.202	1.265	.985	-.688	3.219
Section 5	Equal variances assumed	2.522	.115	1.592	98	.115	1.280	.804	-.315	2.875
	Equal variances not assumed			1.592	88.437	.115	1.280	.804	-.317	2.877

The result of the population sample young adult and older adults t test (see Table 2) showed a significant difference in Scale 1 between young adults and older adults as t – 3.237, df - 100 & p>0.05 and t- 3.237, df – 77.459 & p>0.05 respectively. The t-test shows no significant difference between the 2 age groups with all the sections of Scale 2.

Table 4 – Correlation Between Stigma, Shame and Attitude Towards Mental Health

Correlations							
		SCALE I	**SCALE II SECTION 1**	**SECTION 2**	**SECTION 3**	**SECTION 4**	**SECTION 5**
SCALE I	Pearson Correlation	1	-.135	-.227*	.026	-.140	.044
	Sig. (2-tailed)		.176	.022	.799	.162	.661
	N	102	102	102	101	101	100
SCALE II SECTION 1	Pearson Correlation	-.135	1	.466**	.395**	.456**	.436**
	Sig. (2-tailed)	.176		.000	.000	.000	.000
	N	102	102	102	101	101	100
SECTION 2	Pearson Correlation	-.227*	.466**	1	.527**	.529**	.413**
	Sig. (2-tailed)	.022	.000		.000	.000	.000
	N	102	102	102	101	101	100
SECTION 3	Pearson Correlation	.026	.395**	.527**	1	.576**	.523**
	Sig. (2-tailed)	.799	.000	.000		.000	.000
	N	101	101	101	101	101	100
SECTION 4	Pearson	-.140	.456**	.529**	.576**	1	.607**

	Correlation						
	Sig. (2-tailed)	.162	.000	.000	.000		.000
	N	101	101	101	101	101	100
SECTION 5	Pearson Correlation	.044	.436**	.413**	.523**	.607**	1
	Sig. (2-tailed)	.661	.000	.000	.000	.000	
	N	100	100	100	100	100	100
*. Correlation is significant at the 0.05 level (2-tailed).							
**. Correlation is significant at the 0.01 level (2-tailed).							

The result of PEARSONS CORRELATION showed (look at TABLE 3) that Scale 1 which is Perceived Stigma Scale has a negative correlation (r = -.227*) with Scale 2 Attitude Towards Mental Health Problem Scale, Section 2. This negative correlation is significant at (p<.02 level). Showing weak relationship strength. Scale 1 does not show any correlation with Section 1, Section 3, Section 4 and Section 5.

Scale 2, Section 1 shows a positive correlation with Section 2 (r =.446**) significant at level (p<.000), with Section 3(r= .395) significant at level (p< .000), with Section 4 (r =.456**) significant at level (p<.000) and with Section 5 (r =.436**) significant at level (p<.000). All of these show a weak relationship strength.

Section 2, shows a positive correlation with Section 3 (r =.527**) significant at level (p<.000), with Section 4 (r =.529**) significant at level (p<.000) and with Section 5 (r =.413**) significant at level (<.000). Section 3 and Section 4 shows a moderate relationship strength. Section 4 has a weak relationship strength.

Section 3, also shows a positive correlation with Section 4 (r =.576**) significant at level (p<.000) and Section 5 (r =.523**) significant at the level (p<.000), these show a moderate relationship strength.

Section 4 also shows a significance with Section 5 (r =.607**) significant at the level (p<.000). this seems shows a weak relationship strength.

DISCUSSION

The present study is aimed at evaluating relationship between stigma, shame and attitude and also to understand their influence on young as well as older adults' attitude towards mental health. For the present study the review of literature was done thoroughly and then accordingly our sample were selected. The sample for the study comprised young adults ranging from age 18- 45 years and older adults ranging from 46- above years. The sample consisted of a total of 102 participants, chosen with the help of random sampling. The study consisted of 57.7 % females and 39.4% males. the study is seen to be heavily dominated by female participants samples. Majority of the participants were from India, but there were a few participants from outside of India with Indian nationality, such as Australia and UK. The study included a total of 3 variables -

- Stigma: E. Goffman, defined stigma as a feature, trait, behavior, or reputation which is socially disapproved in a certain way.
- Shame: Shame is a very powerful negative emotion, which is associated with many of the mental disorders, it can be both an etiological factor as well as a consequence

affecting symptom, a psychological defense and a therapeutic outcome. (Jessica. Y. 2018)

- Attitude: Carl Jung defines attitude as "the preparedness of one's psyche to act and react a certain way".

Shame and Stigma are the independent variables while Attitude is a dependent variable in this study. The two scales used to study these variables were Perceived Stigma Scale and Attitude Towards Mental Health Problem Scale; as seen by the name of the scales Perceived Stigma Scale studies how a person sees how his community would perceive mental health; while Attitude Towards Mental Health Problem Scale assesses an individual's attitude towards mental health as well as internal and external shame.

The study was one to prove the following hypothesis
-There is a high correlation between shame, stigma an attitude.
-Young adults would have a low level of stigma a shame, then older adults.
-There exists a difference in the attitudes of young adults and older adults.

For the process of data collection Google forms were made and shared to friends, family and acquaintances. For the statistical analysis of scores SPSS version 21 was applied; the statistical methods used for the analysis are correlation, descriptive statistics and T test. To analyse the correlation among the three variables stigma, shame and attitude, bivariate Pearson correlation was computed. To see how stigma and shame effected the attitudes of young adults and older adults towards mental health, was done through mean and standard deviation. To compute how stigma and shame created a difference in the attitudes between young adults and older adults towards mental health, was done through independent samples T test.

- Scale I– perceived stigma
- Scale II – attitude towards mental health
  - Section 1- individuals perception on how their community and family perceives mental health problems.
  - Section 2- how their community and family see them if they had mental health problems.
  - Section 3- internal shame and negative evaluation of suffering from mental health problems.
  - Section 4- reflected shame and belief about how the family would be seen if any member had a mental health problem.
  - Section 5- fears of reflected shame on self, associated with one's close friend or relative going through mental health problems.

The result of the Pearson correlation shows that the correlation between stigma, shame and attitude is found to be significant.

Scale I is seen to have a negative significant correlation (r=-.227) with Scale II - Section 2. They seem to have a weak correlation.

Scale II, section 1 shows a positive significant correlation with Section 2 (r =.446**), with Section 3(r= .395), with Section 4 (r =.456 and with Section 5 (r =.436**). All of these show a weak correlation strength.

Section 2, shows a positive significant correlation with Section 3 (r =.527**), with Section 4 (r =.529**) and with Section 5 (r =.413**) Section 3 and Section 4 shows a moderate correlation. Section 5 has a weak correlation here.

Section 3, also shows a positive significant correlation with Section 4 (r =.576**) and Section 5 (r =.523**), these show a moderate correlation.

Section 4 also shows a positive significance with Section 5 (r =.607**), it seems shows a weak correlation.

Thus, we can say that stigma, shame and attitude have a weak yet significant relationship. These results coincide with particular research done by Reynders. A. and his associates (2013) who tried to find out the relationship between help seeking behaviors and attitude and stigma. Scales used were Attitudes toward help seeking, perceived stigma, self-stigma, shame and intention to seek help. The result showed that the Population in Netherlands, have a low suicide rate, is seen to have a more positive attitude toward the help seeking attitude and experience a less self-stigma and shame compared to people in the Flanders, where suicide rates are relatively higher.

This research as well as these statistical analysis results provide enough proof for us to say that there is a significant if weak level of correlation, taking from the statistical analysis results as well as the results provided by the research study, we can say that attitude and stigma have a negative relationship e.g.- a positive attitude would lead to low levels of stigma. Shame and attitude also have a significant relationship.

According to the results of the independent sample t test of the presenting study we have found we can say that in respect Scale I, there seems to be a significant difference in Scale I, which is Perceived Stigma Scale, between young adults and older adults where = t – 3.237, df -100 & p>0.05 and t- 3.237, df – 77.459 & p>0.05 respectively.

The results also show that there is no significant difference among the 2 age groups found in Scale II.

Some of the research done has shown – one of such study done by Kyaien and associates in 2010 to see the effect of race and stigma on the help seeking among the older adults with depression. Results showed that older people with depression have a very high level of public stigma due to which they are more likely to not seek for treatment.

Many more studies done by Claire and associates in 2013 and Louise.F and associates, who tried to find difference between older and younger age groups found that more than 70% people both old and young who have mental illness do not receive proper treatment from the proper heath care workers and the second study found the older adults more likely believe that the cause of schizophrenia is weak character. While the younger adults were found to be keener in over identifying depression signals.

One of the studies done by Sushmita.C. and associates in 2015 on the post graduate students of India which tried to find out the attitudes and stigma among post graduate physicians of India towards people with psychiatric illness. The Results showed that participants had

negative view towards people with schizophrenia, but overall, they had positive view on mental health.

Another study done by Alison. L. and his associates in (2010), shows that the level of the perceived stigmas was much higher than the personal depression stigma in the young adults.

So, with the help of these studies as well as the present study's results we can say that there is a significant difference among the young adults as well as older adults perceived stigma where (M= 3.33, SD =.683) & (M= 2.98, SD= .374) respectively, so we can infer that young adult have a high perceived stigma than older adults. As we saw above stigma and attitude are negatively significant, thus we can say that the higher the stigma in young adults, the negative the attitude towards mental health and vice-versa for the older adults population.

Hence, 1 out of the 3 hypothesis that is – there will exist a difference between the attitudes of both the age group towards mental health, was proved to be true. The 2nd hypothesis and the 3rd hypothesis suggested that stigma, shame and attitude would show a high correlation and that young adults would have a low level of stigma a shame, than older adults, both of which we were unable to establish.

CONCLUSION

Mental health is the overall homeostasis of self. It affects how we think, feel, act and behave. Through the various literatures we have reviewed in this paper we can say that it is one of the most undermined and the most lacking sector of the health department all over the world. Numerous literatures accounts for the significant role of mental health, in improving self-esteem, self-concept, coping skills, personal, social and occupational areas of one's life and the overall health of our body. Stigma on the other side is described as the barrier to seeking help for mental health issues and problems. Stigma's gives birth to stereotypes and then further leads discrimination of the stereotyped group, which in this case is people with mental health problems. Discrimination then leads to shame surrounding the topic of mental disorders and help seeking itself. This stigma and shame negatively affect the community or society's attitudes and beliefs towards mental health. But with globalization has come more awareness of the importance of mental health and positivity in life.

The resent study is focused upon investigating the effect of stigma, shame and attitudes of the young adults as well as older adults towards mental health. For these two scales assessing ones perceived stigma as well as attitude and shame were used. The results suggests that stigma, shame and attitude are significant but share a weak relationship. Another finding suggests that young adults have a higher perceived stigma than the older adults.

So, we can conclude by saying that through this extensive research we have found that there is a difference in the attitudes of young adults as well as older adults towards Mental Health.

REFERENCES

Ahuja, Kanika. K., Dhillon., Juneja, M., Sharma. A., & Bhuvaneswari. (2017). Breaking barriers: An education and contact intervention to reduce mental illness stigma among Indian college students. *Psychosocial Intervention*, vol. 26, núm. 2, agosto, pp. 103-109.

Anderson, M., & Standen, P.J. (2007). Attitudes towards suicide among nurses and doctors working with children and young people who self-harm. J *Psychiatric Mental Health Nursing*. 14(5):470-7. doi: 10.1111/j.1365-2850.2007.01106. x. PMID: 17635255.

Calear, AL., Griffiths, KM., & Christensen, H. (2011). Personal and perceived depression stigma in Australian adolescents: magnitude and predictors. *J Affect Disord*.;129(1-3):104-8. doi: 10.1016/j.jad.2010.08.019. Epub 2010 Sep 21. PMID: 20863571.

Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: gender differences in teen willingness to use mental health services. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, *38*(6), 754.e1–754.e7548. https://doi.org/10.1016/j.jadohealth.2005.08.011

Chandramouleeswaran. S., Rajaleelan. W., Edwin. N.C., Koshy. I. (2017). Stigma and Attitudes toward Patients with Psychiatric Illness among Postgraduate Indian Physicians. *Indian Journal Psychology Med*.39(6):746-749. doi: 10.4103/IJPSYM.IJPSYM_84_17. PMID: 29284805; PMCID: PMC5733422.

Choi, NG., DiNitto, D.M., & Marti, C.N. (2014). Treatment use, perceived need, and barriers to seeking treatment for substance abuse and mental health problems among older adults compared to younger adults. *Drug Alcohol Dependance*. 145:113-20. doi: 10.1016/j.10.004. Epub. PMID: 25456572.

Conner, KO., Copeland, VC., Grote, NK., Koeske, G., Rosen, D., Reynolds, C.F. 3rd., & Brown, C. (2010). Mental health treatment seeking among older adults with depression: the impact of stigma and race. *American Journal Geriatric Psychiatry*.18(6):531-43. doi: 10.1097/JGP.0b013e3181cc0366. PMID: 20220602; PMCID: PMC2875324.

E. Sakellari, A. Sourander, A. Kalokerinou-Anagnostopoulou, H., & Leino-Kilpi, (2014). The impact of an educational mental health intervention on adolescents' perceptions of mental illness, *Journal of Psychiatric and Mental Health Nursing*, 10.1111/jpm.12151, **21**, 7, (635-641).

Farrer, L., Leach, L., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2008). Age differences in mental health literacy. *BMC public health*, *8*, 125. https://doi.org/10.1186/1471-2458-8-125

Furnham, A., & Hamid, A. (2014). Mental health literacy in non-western countries: A review of the recent literature. *Mental Health Review Journal*. 19. 10.1108/MHRJ-01-2013-0004.

Gary FA. (2005). Stigma: barrier to mental health care among ethnic minorities. *Issues Mental Health Nursing*.26(10):979-99. doi: 10.1080/01612840500280638. PMID: 16283995.

Gateshill, G., Kucharska-Pietura, K., and Wattis J. (2011). Attitudes towards mental disorders and emotional empathy in mental health and other healthcare professionals. *The Psychiatrist Online*, 35:101-105.

Gibbons, Ray & Thorsteinsson, Einar & Loi, Natasha. (2015). Sex differences in beliefs and attitudes towards mental illness: An examination of mental health literacy in a community sample. 10.7287/PEERJ.PREPRINTS.965.

Gilbert, Paul & Bhundia, Rakhee & Mitra, Ranjana & Mcewan, Kirsten & Irons, Chris & Sanghera, Jasvinder. (2007). Cultural differences in shame-focused attitudes towards mental health problems in Asian and Non-Asian student women. Mental Health. *Religion & Culture*. 127-141. 10.1080/13694670500415124.

Gilbert.P., FBPsS, Professor, Gilbert.J., & Sanghera.J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and

service use in South Asian women living in Derby, *Mental Health, Religion & Culture*, 7:2, 109-130, DOI: 10.1080/13674670310001602418

Hamid, A., & Furnham, A. (2012). Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion & Culture*. 16. 1-18. 10.1080/13674676.2012.718753.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American journal of public health*, *103*(5), 777–780. https://doi.org/10.2105/AJPH.2012.301056.

Jang, Y., Chiriboga, D.A., & Okazaki S.(2009). Attitudes toward mental health services: age-group differences in Korean American adults. *Aging Mental Health*. 13(1):127-34. doi: 10.1080/13607860802591070. PMID: 19197698; PMCID: PMC2737391.

Joana Moura Cabral Master, Célia Maria de Oliveira Barreto Carvalho, Carolina Dall'Antonia Motta, Marina Correia Sousa & Paul Gilbert (2016) Attitudes towards mental health problems scale: Confirmatory factor analysis and validation in the Portuguese population. *American Journal of Psychiatric Rehabilitation*, 19:3, 206-222, DOI: 10.1080/15487768.2016.1197860.

Kelly, C.M., Jorm, A.F., & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. Med J Aust.1;187(S7): S26-30. doi: 10.5694/j.1326-5377. 2007.tb01332. x. PMID: 17908021.

Lauber C, Rössler W. (2007). Stigma towards people with mental illness in developing countries in Asia. *Int Rev Psychiatry*.19(2):157-78. doi: 10.1080/09540260701278903. PMID: 17464793.

Livingston JD, Tugwell A, Korf-Uzan K, Cianfrone M, Coniglio C. (2013). Evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues. *Social Psychiatry Psychiatric Epidemiology*. 48(6):965-73. doi: 10.1007/s00127-012-0617-3. Epub 2012 Nov 3. PMID: 23124481.

Mackenzie, C.S., Gekoski, W.L., & Knox, V.J. (2006). Age, gender, and the underutilization of mental health services: the influence of help-seeking attitudes. *Aging Mental Health*.10(6):574-82. doi: 10.1080/13607860600641200. PMID: 17050086.

Madianos., Michael., & Priami., Maria., & Alevisopoulos., George., & Koukia., Evmorfia., & Rogakou., Efi. (2005). Nursing student's attitude change towards mental illness and psychiatric recognition after a clerkship in psychiatry. *Issues in mental health nursing*. 26. 169-83. 10.1080/01612840590901635.

Pinfold., Vanessa., & Stuart., Heather., & THORNICROFT., GRAHAM., & ARBOLEDA., JULIO. (2005). Working with young people: The impact of mental health awareness programmes in schools in the UK and Canada. World Psychiatry. 4.

Quinn, K.M., Laidlaw, K., & Murray, L.K. (2009). Older peoples' attitudes to mental illness. *Clinical Psychological Psychotherapy*. 33-45. doi: 10.1002/cpp.598. PMID: 19170041.

Reynders, A., Kerkhof, A.J., Molenberghs, G., Van, Audenhove, C. (2014). Attitudes and stigma in relation to help-seeking intentions for psychological problems in low and high suicide rate regions. *Social Psychiatry Psychiatric Epidemiology*.;49(2):231-9. doi: 10.1007/s00127-013-0745-4. Epub 2013 Jul 30. PMID: 23896893.

Robb, C., Haley, W.E., Becker, M.A., Polivka, L.A., Chwa, H.J. (2013). Attitudes towards mental health care in younger and older adults: similarities and differences. *Aging Mental Health*. 7(2):142-52. doi: 10.1080/1360786031000072321. PMID: 12745392.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry Psychiatric Epidemiology*. 35(7):326-34. doi: 10.1007/s001270050246. PMID: 11016528.

Soorkia, R., & Snelgar., Rosemary., & Swami, V. (2011). Factors influencing attitudes towards seeking professional psychological help among South Asian students in Britain. *Mental Health. Religion & Culture*. 613-623. 10.1080/13674676.2010.494176.

Vizin, G., Unoka, Z. (2015). A szégyen szerepe a mentalis zavarok kialakulásában II. A szégyen mérése és a szégyen kapcsolata a mentális zavarokkal [The role of shame in development of the mental disorders II. *Measurement of shame and relationship. Psychiatric Hung*.30(3):278-96. Hungarian. PMID: 26471030.

Watson, A., & Miller, F., & Lyons, J. (2005). Adolescent Attitudes Toward Serious Mental Illness. *The Journal of nervous and mental disease.* 193. 769-72. 10.1097/01.nmd.0000185885.04349.99.

Woodward, R., & Pachana, N. (2009). Attitudes towards psychological treatment among older Australians. *Australian Psychologist*. 44. 10.1080/00050060802583610.

Yap, M.B., Mackinnon, A., Reavley N., & Jorm, A.F. (2014). The measurement properties of stigmatizing attitudes towards mental disorders: results from two community surveys. *Int J Methods Psychiatr Res*. 23(1):49-61. doi: 10.1002/mpr. 1433. PMID: 24550065; PMCID: PMC6878256.

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Conflict of Interest

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