The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 12, Issue 2, April- June, 2024
DIP: 18.01.232.20241202, DOI: 10.25215/1202.232
https://www.ijip.in

Research Paper

Evaluating the Progression of Mental Health Literacy and Various Stigmas across Different Generations

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ABSTRACT

The goal of the study was to observe the changes in patterns of awareness, literacy, stigma and acceptance of mental health disorders and issues, particularly across generations. The paper focuses on assessing the levels of literacy and knowledge, and gauging the level of stigma (social, internal, and anticipated) inlayed into the population's perception of mental health and illness as a concept. The target population included individuals aged between 20 to 65 years. The sample was divided into three parts, based off approximation of generational shifts. A total of 150 individuals participated in this study, 50 from each age group. The age groups were divided into younger adults (20-35 years), middle aged adults (35-50 years) and older adults (50-65 years). The Mental Health Knowledge Schedule, Mental Health Literacy Scale, and the Stigma and Self Stigma Scales were used to collect data. One-way ANOVA was run between the groups, and it was found that there was a significant difference ($F_{2,147} = 7.439$, $p<.001$) in mental health literacy levels as well as in the prevalence of stigmas. Post-hoc comparisons revealed that there was a significant difference in the means of mental health literacy between the youngest age group and both the older groups. The older groups did not, however, see any significant difference between each other. The domains of Anticipated Stigma, Self-Stigma and Help-Seeking/Disclosure were concluded to show no significant differences across all three groups. The Stigma to Others domain saw significant differences ($F_{2,147} = 8.488$, $p<.001$). It was found that there was a significant difference between the youngest and both the older groups, but not between the older groups themselves. The Social Distance domain was found to have significant differences ($F_{2,147} = 4.360$, $p=.014$), but further analysis found differences only between the younger adults and middle-aged adults. The study finds that there is a very significant shift in the levels of mental health literacy and a decline in stigmas in society. The study concludes that there is lower stigma in the older generations, and progress in the level of mental health awareness and literacy, despite differences and scope for further improvement.

Keywords: *Mental Health Literacy, Awareness, Multiple Stigmas, Different Age Groups, Generational Shift, Mapping Progress*

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Received: March 17, 2024; Revision Received: May 25, 2024; Accepted: May 28, 2024

Evaluating the Progression of Mental Health Literacy and Various Stigmas across Different Generations

In the modern-day scenario, the field of psychology has progressed by leaps and bounds, as we see the catering of mental health to take a front seat in various domains. Counselling psychologists in schools and mental health workshops and policies in workplaces have been mandated by multiple governments across the world. Plenty emphasis is being placed on the importance of mental health and awareness campaigns are constantly organised for the sake of spreading awareness. The World Health Organization (WHO) has solidified the definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Constitution, 2024), and while this definition has been integrated into education systems and healthcare practices, the question stands whether the concept of 'mental and social well-being' has been thoroughly integrated into the minds of the people. While this definition lays equal emphasis on both mental and social well-being as an important part of attaining the ideal state of 'health', it can be said that the same is far from being applied into practice – a strong gap can be seen between the implementation and actual impact of mental health practices.

When talking about mental health, the question arises whether there is a true understanding of what mental health encompasses in the society, particularly in a country like India, where the populations' perception of psychological issues is considered relatively backwards. Health literacy has been defined as "ability to access, understand, and use the information to promote and maintain good health" by Nutbeam & Wise (1993). Mental health literacy can be said to comprise of the knowledge to seek mental health information and professional help, the right attitudes to facilitate recognition of problems and seeking help, the belief and knowledge of causes and self-help behaviours, and the ability to recognize psychological distress (Jorm, 2000). Another important aspect of mental health literacy to note is the conceptual difference between mental health and mental illness. While these issues are related, and there is no "widely agreed consensus" on their meanings, mental health is used to denote the absence of a mental illness, and 'attaining' mental health can refer to "a state of well-being in which the individual introspects his or her own abilities, can cope with normal stresses of life, as well as can work productively and fruitfully and is able to make a contribution to his or her own community" (De, Haldar, & Biswas, 2022). On the other hand, a mental illness is any condition that significantly disrupts or impairs the 'normal' mental functioning, and as a result, well-being of a person.

As by human nature, despite wider acceptance and better understanding of this field, it will take many years still to truly inculcate, implement, and most importantly, have acceptance of mental health conditions and practices. It is not an easy task to promote the concept of mental well-being to individuals from a generation where catering to mental strain was considered a distraction from various other 'important' issues of the time. In a time where these issues have been resolved, it must be kept in mind that the target audience includes people from different generations, all with different coping styles, traumas, and perceptions, moulded by the major crises of their times. Gusain et al. (2019) evaluated factors affecting mental health awareness in adults in Dehradun (Uttarakhand). It was found that superstitious belief, history of mental illnesses and peer influences played a significant role in lack of mental awareness. In a study conducted by De et al. (2022) comparing the "level of knowledge and attitude towards mental illnesses" amongst younger and older people in a rural community in Bankura, West Bengal, it revealed that both the knowledge and attitudes score means were higher in the younger population as compared to the older at a significant level. They also concluded a positive correlation to exist between knowledge and attitudes.

What is potentially unique to Asian societies, is the wilful ignorance practiced by the older generations, who lay great emphasis on having had to give up on considering personal emotions of value in order achieve a sustainable lifestyle. Hence, progress towards mental awareness and literacy must be made by tapping into their concepts and practices of well-being. Lee et al. (2023) conducted an analysis evaluating the "roles of knowledge of professional help and mental health, and attitudes towards mental health" in the level of mental health awareness. The results depicted that knowledge of mental health was strongly influenced by attitudes towards mental health. Media exposure was observed as an important factor in knowledge and attitudes.

A prevalent enemy of this progress known as stigma is defined by the APA as "the negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency; it implies social disapproval and can lead unfairly to discrimination against and exclusion of the individual" (APA Dictionary of Psychology, n.d.).

As per common classification, stigma is divided into three types (Borrenstien, 2020):
Public stigma, which includes the negative or discriminatory attitudes that people may have and direct towards those with mental illness.

Self-stigma, referring to negative inhibitions and perceptions, like internalized shame, that people with mental conditions develop about themselves.

Institutional stigma, as the name suggests, involving government and company policies that are specifically designed to, or indirectly limit opportunities for people with mental illness.
Erving Goffman, a Canadian social psychologist from the 20th century, was most renowned for his work on stigma. In his theory of public stigma, stigma is defined as "an attribute, behaviour, or reputation which is socially discrediting in a particular way: it causes an individual to be mentally classified by others in an undesirable, rejected stereotype rather than in an accepted, normal ones" (Goffman, 1963). The Modified Labelling Theory (MLT) states that "negative external perceptions such as public stigmatization can have a harmful impact on a person's internal sense of self, as the person applies these perceptions, stereotypes, and biases related to mental illness to his or her self-concept" (Link, 1987). In simple terms, the stigmatization of mental illness by the public leads to broken sense of self, impacting esteem, self-image, and confidence. This leads to internalization, which can be surmised as self-stigma.

Gaiha, Raman et al. (2020) conducted a review and analysis on the stigma related to mental health problems amongst the younger Indian population. They found that at least a third of this population display poor knowledge and hold negative attitudes towards individuals with mental health problems and that "one in five had actual/intended stigmatizing behaviour". They note that these individuals are unable to recognize the prognosis and symptomology of mental health problems and believe that recovery is unlikely. Bragg et al. (2018) conducted a preliminary study assessing the mental health literacy and attitudes towards mental disorders in a population divided into younger and older adults. The results found that younger adults had more knowledge about anxiety disorders while older adults had so for personality disorders. Older adults were seen to have more favourable attitudes towards depression and mania than younger adults.

Another type of stigma that is observed is the perceived public stigma, or the anticipated stigma, referring to stigma that may or may not be there, but regardless is perceived and people with mental conditions worry about being stigmatized and discriminated due to the awareness of existing stigmas. Stigma also exists towards help seeking behaviours, resulting in a severe discrepancy in the ratio of those suffering from mental illness and those seeking help.

It was observed that lesser studies exist attempting to understand prevalence of different types of stigmas, particularly anticipated stigmas. It was also observed that in similar research only two age clusters were taken for age comparisons. The rationale of taking three clusters stems from the need for in-depth research, and to find the difference between different generations in the society, mapping changes more clearly. This study investigates the progress that has been made over time in the spread of awareness and mental health literacy. It additionally assesses the level of different stigmas ingrained into the population and its relation to the literacy levels via a comparative study between three age populations.

METHODOLOGY

Aim

To assess the role of generational shifts in the level of mental health awareness and prevalence of different types of stigmas across three generations.

Objectives

The study attempts to understand the relationship of generational shifts in an ever-evolving society, with the level of literacy and understanding regarding mental health in the following age groups:

- 20 years to 35 years
- 35 years to 50 years
- 50 years to 65 years

The study also aims to assess the level of, and the relationship of these stigmas (social stigma, self-stigma, etc.) with the formation of these opinions and schemas across the generations and assess its relationship with the amount of awareness.

Hypotheses

- **H1** - There will be a significant difference in the level of mental health literacy in individuals aged between 20-35 years and 35-50 years.
- **H2** - There will be a significant difference in the levels of mental health literacy in individuals aged between 35-50 years and 50-65 years.
- **H3** - There will be a significant difference in the levels of mental health literacy in individuals aged between 20-35 years and 50-65 years.
- **H4** - There will be a significant difference in the level of stigmas in individuals aged between 20-35 years and 35-50 years.
- **H5** - There will be a significant difference in the level of stigmas in individuals aged between 35-50 years and 50-65 years.
- **H6** - There will be a significant difference in the level of stigmas in individuals aged between 20-35 years and 50-65 years.

Variables

Dependent Variables

The participants' measured levels of mental health awareness and literacy were the main variables of the study, along with the prevailing social stigmas interlaid into their cognition, the self-stigma developed and internalized from the same, anticipated stigmas and stigmas towards help-seeking.

Independent Variables

The independent variable, which was the pivotal focus of the study, was the generational shift that naturally takes place over time. Society sees a shift in the norms, opinions, and traditions with the passage of time, and this has enabled the concept of mental health to eventually be brought out in the open and gain acceptance. The study focuses on the differences that can be observed between three such generations, and whether these shifts have truly brought about any change in mental health literacy and stigma.

Data Collection

The data collection process was done via convenience sampling and snowball sampling - participants were approached in convenient settings like libraries, cafés, neighbourhoods, and local parks. Many respondents were also asked to pass on the forms to eligible individuals to enable a larger scope of data collection. Responses were also collected online via google forms (n=30). The questionnaire consisted of three scales set up to first gain a brief insight into their understanding of the concept of mental health, and their level of literacy, and then to assess their levels of mental health literacy and various stigmas. One preliminary question was added in the sociodemographic form, inquiring whether the participant has ever had a formal diagnosis of mental illness.

Sample

The aim was to gather responses from three different age groups, divided on the basis of approximate shifts in societal adjustment. The first group was ranged from 20 years to 35 years, encompassing the younger adults, most adjusted to current society. The second group was consistent of middle-aged adults - 35 years to 50 years - falling between the two categories. The last was 50 years to 65 years, the older generations assumed to be least adjusted to modern changes than the rest. The total sample consisted of 150 participants, of which it was ensured an equal sample be acquired of each age group.

Table 1 Sample Descriptives

	20-35 years	**35-50 years**	**50-65 years**	**Total**
N	50	50	50	**150**
Female Respondents	33 (66%)	27 (54%)	19 (38%)	**79**
Male Respondents	15 (30%)	22 (44%)	31 (62%)	**68**
Others	2 (4%)	1 (2%)	0	**3**
With Prior Diagnosis	6	2	0	**8**

Of this sample, 5 respondents were noted to have a diagnosis of a mental disorder (Anxiety Disorders, Depression, ADHD, and Schizophrenia), with 3 others opting to not reveal said diagnosis. Of these, 6 participants were aged below 35, and 2 between 35 - 50. There were no specific criteria for selecting the participants, except the age group. Signed and informed consent was taken before the data collection. The participants were briefed on the nature of research before taking consent.

Tools

Mental Health Knowledge Schedule. The first 6 items of the schedule briefly ask about stigma-related knowledge areas (employment, recognition, support, recovery, treatment, and help-seeking). Items 7 onwards aim to establish the level of recognition and clarify the concept of illness of the respondent. The scale is scored on an ordinal scale from 1 – 5, rating from 'Disagree Strongly' to 'Agree Strongly'. An additional option of 'I Don't Know' exists for better evaluation and is scored as 3 for scoring. The items 6, 8, and 12 and reverse scored. The schedule was not developed with the intention to function as a scale, but rather to gain insight on specific areas of knowledge.

Mental Health Literacy Scale. The scale focuses on covering the following aspects of mental health literacy, using the definition given by Jorm et al (1997):

- Ability to recognize disorders.
- Knowledge of where to seek information.
- Knowledge of self-treatment.
- Knowledge of professional help available.
- Attitudes that promote help seeking behaviours.

Scoring was based off a 4-point Likert Scale in the first half, and a 5-point Likert Scale in the second half. The highest possible score was 160 indicating higher literacy, and minimum score was 35.

Stigma and Self Stigma Scale. The scale was designed to measure 6 dimensions of stigmas, with an additional dimension of Social Desirability. This study only focuses on 5 of these dimensions, focusing solely on stigmas:

- Stigma to others, assessing the individual levels of 'public' stigma to others.
- Social Distance, while not stigma, assesses the perceived comfort and closeness towards those with mental illness. This subscale is entirely scored in reverse.
- Anticipated Stigma, assessing the perceived stigmas and fear of stigmatization.
- Self-Stigma, assessing the level of internalized stigmas and shame.
- Help-Seeking/Disclosure, assessing inhibition towards disclosure and seeking help.

The Avoidant Coping and Social Desirability sub-scales were not included. Each sub-scale is scored separately, with minimum score being 0, and maximum score being 24, higher scores indicating higher stigma. The items were rated on a Likert Scale of 0 – 4, 0 indicating 'Strongly Disagree' and 4 indicating 'Strongly Agree'.

Statistics

The statistical analysis was conducted via one way ANOVA with the mental health literacy and various stigmas as the dependant variables and the age groups as the independent variable. IBM SPSS free trial version was utilized for all statistical procedures.

The first questionnaire (MAKS) was not included in the analysis for two reasons: the purpose of including the questionnaire in the study design was purely to gain a brief insight on the inclination of each populations' possible responses, the results of the which, as later discussed, are found to hold no significant variance, hence showing deviance from the rest of the study.

Design

The study follows a comparative design, attempting to evaluate the difference between the groups in regard to the chosen variables. In today's fast-moving world, acceptance towards mental health, related conditions and illnesses has been quickly established as a basic and humanitarian need and norm. This shift has seen its own share of struggle and has yet to completely be accepted by the entirety of society.

The purpose of this study was to gain an insight into the current prevalence of mental health literacy and awareness, and the acceptance towards those with mental health struggles. Stigmas play a huge role in how society's perception of these individuals are conceptualized and pose a hurdle to acceptance and understanding of mental health issues.

The study was formulated with certain questions in mind:

What kind of shift has occurred in the level of mental health awareness and acceptance with the generational shifts – has there been an increase, decrease, or a stagnancy in this development?

How prevalent are the stigmas and self – stigmas towards mental health in society, and has there been a shift over time? If so, is this shift affecting the shift in awareness and acceptance in any way?

RESULTS AND DISCUSSION

The data was collected over three scales was then scored and evaluated. The data from the Mental Health Knowledge Schedule was analysed for a brief overview of the trends.

Mental Health Knowledge Schedule

Table 2 MAKS Results Descriptives

Group	N	Mean	Std. Deviation	Std. Error	Minimum	Maximum
20-35	50	45.06	4.934	.698	32	**56**
35-50	50	46.18	3.462	.490	38	**54**
50-65	50	45.78	4.863	.688	31	**56**

As seen in Table 2, the mean results are seen to be almost the same for each group, indicating no significant difference in the scores. This implies a relatively normal and consistent level of mental health knowledge throughout the population. The questions of the schedule briefly measure different domains, and hence do not provide deeper and precise information.

- **In Group 1.** Fifty percent of the respondents are seen to score above the average score of 45, indicating fairly high levels of knowledge. However, the same percentage of population have also opted for the 'I Don't Know' option for at least 2 items, up to 4 times.
- **In Group 2.** About 42% of the population scored above the average score of 46. This population sees the highest occurrence of the response 'I Don't Know', with 30 respondents (60%) opting the same.
- **In Group 3.** Unexpectedly, this population sees the highest percentage (60%) of respondents scoring above the average of 45. The results also saw the lowest

occurrence of the response 'I Don't Know' with only 22 respondents opting for the same.

While the results reflect a relatively high level of knowledge, it is to be noted that that the presence of knowledge does not equate to the presence of literacy. It is hence to be noted that the high frequency of 'I Don't Know' responses indicate a lack of literacy, despite some level of awareness. This was further analysed by conducting a one-way ANOVA on the results of the Mental Health Literacy scale.

Mental Health Literacy Scale

The initial hypotheses tested for a significant difference between the presence of mental health literacy between the three groups [as indicated before, Group 1(20-35), Group 2(35-50) and Group 3(50-65)]. Upon testing, the ANOVA results indicated the mental health literacy levels of the groups to have a significant difference ($F_{2,147} = 7.439$, $p<.001$). Upon running a test of homogeneity of variances, it was found that equal variance was assumed. To properly test the three hypotheses, and check for individual differences between groups, post-hoc comparisons were conducted using Scheffe's procedure. These results were tested for significance at the 0.05 level.

Table 3 ANOVA Results for Mental Health Literacy

Test of Homogeneity of Variance		**ANOVA**	
Levene Statistic	**Sig.**	**F**	**Sig.**
0.756	0.472	7.489	0.001

The results found that the mean score of Group 1 (M=120.8, SD=13.12) was significantly different from Group 2 (M=111.4, SD=10.76). Hence the first hypothesis (H1) is accepted, with the younger generation having higher mental health literacy. The mean score of Group 1 (M=120.8, SD=13.12) was also found to be significantly different from Group 3 (M=114.3, SD=13.32). Hence the second hypothesis (H2) is also accepted, with the younger generation again having higher mental health literacy. These results are supported by various studies, like one done by Haldar et al. (2022) assessing and comparing the level of knowledge and attitude towards mental illnesses amongst younger and older people in a rural community in Bankura, West Bengal. Results revealed that both the knowledge and attitudes score means were higher in the younger population as compared to the older at a significant level. They also concluded a positive correlation to exist between knowledge and attitudes.

Table 4 Post-Hoc Results for Mental Health Literacy (Scheffe's Procedure)

Groups (I)	**Groups (J)**	**Mean Difference (I-J)**	**Sig.**	**95% Confidence Interval**	
				Lower Bound	**Upper Bound**
1	2	9.420*	0.001	3.26	15.58
	3	6.500*	0.036	0.34	12.66
2	1	-9.420*	0.001	-15.58	-3.26
	3	-2.920	0.505	-9.08	3.24
3	1	-6.500*	0.036	-12.66	-0.34
	2	2.920	0.505	-3.24	9.08

** The mean difference is significant at 0.05 level.*

However, it was seen that the mean score of Group 2 (M=111.4, SD=10.76) was not significantly different from Group 3 (M=114.3, SD=13.32). Hence the third hypothesis (H3) is rejected, with the older generation between the two surprisingly having a non-significantly higher mental health literacy.

Stigma and Self Stigma Scale

The latter hypotheses tested for a significant difference between the presence of various types of stigmas in the three groups. The scale consisted of five different sub-scales, and analysis was conducted for each separately. Upon testing, the ANOVA results indicated the Stigma to Others results of the groups to have a significant difference ($F_{2,147}$ = 8.488, p<.001). Likewise, the Social Distance results of the groups were seen to have a significant difference ($F_{2,147}$ = 4.360, p=.014).

The sub-scales of Anticipated Stigma ($F_{2,147}$ = 2.061, p=.131), Self-Stigma ($F_{2,147}$ = 1.910, p=.152) and Help-Seeking/Disclosure ($F_{2,147}$ = .088, p=.916) were seen to produce no significant difference between the groups and were not run for any post-hoc comparisons. Another similar study (Longkumer & Borooah, 2016) aimed to observe the attitudes held by Nagas towards mental disorders, and its relationship to age and gender with a sample comprised of two age groups – 21 to 40 years and above 50 years. They observed that there was a significant level of difference between the age groups, and that the attitudes strongly indicated stigma.

Table 5 ANOVA Results for Stigma

Sub-Scale	**Test of Homogeneity of Variance**		**ANOVA**	
	Levene Statistic	**Sig.**	**F**	**Sig.**
Stigma To Others	0.205	0.815	8.488	<.001
Social Distance	1.740	0.179	4.360	0.014
Anticipated Stigma	4.129	0.018	2.061	0.131
Self-Stigma	2.453	0.090	1.910	0.152
Help-Seeking/Disclosure	3.126	0.047	0.088	0.916

For the first two sub-scales, a test of homogeneity of variances was done, and it was found that equal variance was assumed. To properly test the three hypotheses, and check for individual differences between groups, post-hoc comparisons were conducted using Scheffe's procedure. These results were tested for significance at the 0.05 level.

The results for Stigma to Others found that the mean score of Group 1 (M=6.76, SD=4.31) was significantly different from Group 2 (M=9.86, SD=4.3), with the younger generation having significantly lower stigma towards others. The results for Group 1 and Group 3 (M=9.56, SD=3.8) also reflect a significant difference. The means of Group 2 and Group 3 however, do not depict any significant differences.

Similarly, in the Social Distance sub-scale, it was seen that the mean score of Group 1 (M=7.56, SD=3.11) was significantly different from Group 2 (M=9.08, SD=2.46), with the older generation having significantly higher social distance with individuals having mental illness. The results for Group 1 and Group 3 (M=8.78, SD=2.55) were, however seen to reflect no significant difference. The means of Group 2 and Group 3 also do not depict any significant differences.

The results conclude that H4 is partially accepted, with significant differences being recorded in Stigma to others and Social Distance in age groups 1 and 2, with the younger group displaying lesser stigma and more social comfort. The hypothesis is only partially accepted, as the other domains reported no significant differences.

H5 is completely rejected, as no significant differences were found in any of the dimensions of stigma between group 2 and 3. The middle-aged population reports higher stigma than the older population in all the domains by the smallest margin, with only stigma towards Help-Seeking/Disclosure being higher for the older group.

Table 6 ***Post-Hoc Results for Stigma (Scheffe's Procedure)***

Sub-Scale	Groups (I)	Groups (J)	Mean Difference (I-J)	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Stigma To Others	1	2	-3.100*	0.001	-5.15	-1.05
		3	-2.800*	0.004	-4.85	-.75
	2	1	3.100*	0.001	1.05	5.15
		3	.300	0.937	-1.75	2.35
	3	1	2.800*	0.004	.75	4.85
		2	-.300	0.937	-2.35	1.75
Social Distance	1	2	-1.520*	0.001	3.26	15.58
		3	-1.220	0.036	0.34	12.66
	2	1	-1.520*	0.001	-15.58	-3.26
		3	.300	0.505	-9.08	3.24
	3	1	1.220	0.036	-12.66	-0.34
		2	-.300	0.505	-3.24	9.08

* *The mean difference is significant at 0.05 level*

The observation of no significant differences between the 35-50 cluster and the 50-65 cluster can be attributed to the 'transitioning phase' taking place during the time of the 35-50 cluster's youth, leading to missed opportunities, influenced due to the older generations and the lack of appropriate tools and knowledge. It can be justified that there has been a shift in general awareness however, with the observation that both the clusters scored relatively low scores in the social distance, and help-seeking domains, and scored average and slightly above average scores on mental health literacy – indicating that while literacy and awareness is not as high as the younger generations, there definitely has been progress in the general outlook and social acceptability.

H6 is partially accepted, with a significant difference only in the Stigma to Others domain between group 1 and 3, with the younger generation observing lower stigma.

All three groups are observed to have particularly high levels of Anticipated Stigma and Self-Stigma yet surprisingly low scores in Help-Seeking/Disclosure. Jennings et al. (2015) found in their study assessing the relationship between self-stigmas, perceived stigmas, and self-reliance with willingness to seek treatment that these factors are significantly related. Higher anticipated stigma was observed to relate to higher self-stigma, which in turn was related to higher self-reliance, which was seen to indicate higher reluctance to seek treatment. While all groups in the current study scored very high in perceived stigma and self-stigma, there is lower stigma towards seeking help and disclosing their problems. This does not necessarily indicate actual help-seeking behaviours. While this does not align with

the findings of the study, it is to be noted that in the duration between this study and theirs, significant changes have taken within the society's mental health perceptions.

It was observed in the respondents that had prior diagnosis of a mental disorder that those who have revealed their diagnosis show comparatively low levels of overall stigma, while still scoring highest in anticipated stigma. One respondent was seen to have stigma scores close to nil. Those who opted to not reveal the nature of their diagnosis were seen to have particularly higher levels of stigma, also scoring higher in stigma to others.

Bivariate correlation was additionally done between the stigma domains and mental health literacy. All domains were significantly negatively correlated to mental health literacy at 0.01 level, showing a strong inverse relationship.

The rationale of the study was to observe the results for a progression and conclude whether these variables observe any change due to the progress over time and generational shifts. The study concluded that there indeed is a strong shift and rise in mental health literacy and decline in stigmas with the changing of times.

CONCLUSION

The aim of this research was to assess the role of generational shifts in the level of mental health awareness across three generations, and to evaluate the relationship of stigmas with these differences. The objectives of the study were to understand the relationship of generational shifts, with the level of awareness and understanding regarding mental health in the three chosen age groups. It also aimed to view the role played by stigmas (social stigma, self-stigma, etc.) in the formation of these opinions and schemas across the generations and assess its relationship with the amount of awareness.

Overall, the study found that there has been a significant shift in the level of mental health literacy and the various stigmas in the past two decades. The population initially reports relatively high levels of mental health knowledge, but further analysis reveals that there is a significant difference between the younger generations and the older clusters. However, both the older generations also reflect improving mental health literacy and an openness to learn and overcome stigmas. The highest reflection of stigma is seen in anticipated sigma and self-stigma, indicating a fear of societal outcasting and self-doubt. Surprisingly low scores are seen in help-seeking domains, which shows contradiction to predictions of various studies, leaving room for further analysis.

Recommendations

The study has scope for further research addressing the issues of stigma and its relation to mental health literacy in more depth. The study finds that the middle generations face more anticipated stigma than any other group. Surprisingly, the older generations have lesser stigma than this group, although not significantly different, and this leaves room for further analysis. There was also a lack of scales looking to the perceptions on mental 'health' rather than on mental illnesses. The difference and the conceptual misunderstanding of the two are observed in response patterns and was found even in research.

The study shows there is potential to properly gauge and differentiate the mental health literacy and knowledge of the public, as stigmas can exist with knowledge, and acceptance can exist with stigmas. The field offers much more than current evaluations. Research and

awareness campaigns and programmes may direct their focus on bridging the gaps by understanding the reason for this discrepancy.

Limitations

Due to the self-report nature of the scales, there is risk of bias and human error from the respondents, influenced by a variety of factors. One must consider that the study was conducted over a limited geographical demographic and may have some resultant biases. There is also a risk of error due to human factors like conformity, bias, insincerity, etc. Another limitation may be due to the lack of resources and with this being preliminary research, there is room left for further analysis and research.

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Acknowledgment
To the Amity Institute of Psychology and Allied Sciences, for providing me with the knowledge and tools to successfully conduct research and hone my skills for writing this paper. To all the participants for their cooperation in this project.

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Saakshi & Mitra, R.K. (2024). Evaluating the Progression of Mental Health Literacy and Various Stigmas across Different Generations. *International Journal of Indian Psychology*, *12*(2), 2670-2682. DIP:18.01.232.20241202, DOI:10.25215/1202.232