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Social perception of mental illness

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Abstract. Mental disorders have been known in all cultures from ancient times to the present day. In the past, most peoples believed that supernatural beings such as deities, spirits and ghosts were responsible for these disorders and resorted to religious rituals to get rid of them. Even today, the ideologies, values and beliefs of each cultural context have a great influence on the manifestation of symptoms of mental illness and the choice of treatment. Perceptions of behaviours that were once considered psychopathological have changed and are now treated differently by psychiatry. People with psychological problems have always been treated with particular suspicion and even fear by society at large. It was common practice to expel them from the community and confine them to an institution. Stigma towards people with mental illness is a long-standing and widespread phenomenon, leading to profound anxiety, disability and negatively affecting quality of life.

Keywords. Perception, mental illness, mental disorders.

1. Mental illness

Mental illness is a health problem that significantly affects the way a person feels, thinks, behaves and interacts with other people. Diagnosis is made according to standard criteria. The term mental disorder is also a term used when referring to these health problems.

In the 1960s and 1970s, a person with a mental illness was just diagnosed and there were several broad classes of mental disorders. National statistics were reported with diagnoses (e.g. schizophrenia cases and depression cases). People with mental illness were usually stigmatised and institutionalised. At the same time, de-institutionalisation had started rapidly.

There was a significant change in care practices in the 1980s and 1990s. The national approach to the care of people with severe mental illness failed to meet their needs. Large numbers of people with severe mental illness were released from public psychiatric hospitals, but few community mental health services could be used to serve them. The population of mentally ill homeless people was growing rapidly. New definitions were needed to identify people with the most severe mental illness and to create a framework for new national programmes. The official work of the National Institute of Mental Health showed that diagnosis alone was not enough and the additional concepts of disability and duration were added.

Disability refers to significant limitations in personal activities, and duration refers to the duration of the disability and had a minimum of one year. These concepts refined a definition of people with "severe and persistent mental illness" that is still used in mental health (Grob, 1995).

Mental illness, as a scientific term, attempts to interpret a range of symptoms of a person's thinking, emotions and behaviour (Oikonomou, 2011).

Attempting to objectively define the normal-pathological runs the risk of an irregularity with significant consequences, since pathology in psychiatry is linked to social rejection and social stigma (Kaprinis, 1988a, p. 82).

In this sense, the term 'mental illness' is difficult to define. In psychiatric practice, in the process of assessing mental disorder, normal and pathological are not measurable quantities and therefore not objectively determined (Skaragas, 2011, pp.57-59).

Goldman et al., (1981), in their attempt to contribute to the development of a national policy for the chronically ill, introduced three criteria (diagnosis, duration, impairment of functionality), recognising the limitations of clarifying the term.

They argue that symptoms are classified as disorders (diagnosis) when they last, recur and are associated with severe personal discomfort and/or impaired functioning in one or more areas of daily life (Skaragas et al., 1981). According to the above criteria, mental disorder is defined and determined.

According to Franco Basaglia (1979), mental illness is a social-historical product that has its own history and reasons for existence. This approach is an attempt to investigate mental illness not only as a biologically defined phenomenon, co-occurring psychologically and sociologically, but also as a cultural and sociological construct reflecting the rules, norms, social ideologies of the social and cultural environment. Thus, the emergence of mental illness and the way it manifests itself is perceived, treated and is the result of the individual's interaction with the economic, political, social and cultural conditions prevailing in the given space-time context (Basaglia, 1979).

2. Historical perspectives on the mentally illness

The stereotype of the dangerous mentally ill seems to be deeply ingrained in the collective consciousness of modern societies (Skaraga, 1997, p. 6). Mental illness is traditionally identified with something bad and threatening (Richard Van Dorn et al., 2012, p. 494) is often found through empirical research. In particular, as the relevant research shows, the general public considers the mentally ill to be characterised by unpredictability (Stuart, 2003, p. 122) and to be uncontrollable, while his possible crime is always treated as 'pointless', 'incomprehensible', unmotivated, a result of his madness (Tsalikoglou Fotini, 1987).

At the same time, when a particularly violent and heinous crime becomes known, the public, motivated by the media, rushes to attribute it to pathological factors (Skaraga, 2002, p. 15). before and independently rushes to attribute it to pathological factors in any psychiatric assessment.

The first signs of the demonisation of mental illness have been found by archaeologists in different parts of the world: drilled skulls dating from the Neolithic era to early humanity. The drilling method Faria, (2013) considered a forerunner of modern psychosurgery, was most likely applied as a "cure" to people with abnormal behavior, which could be due to epilepsy, mental illness or even an unbearable headache. By drilling a hole in the skull, the tribe believed they were offering

a method of escape from the demonic spirit that had entered the patient's body so that normal behaviour could be restored.

Despite the progress made in ancient Greece and the Greco-Roman era towards a scientific approach to mental illness, the theocratic formation of society in the Middle Ages Skaraga, 1997, p. 17).

Of particular interest in this period is the interpretative approach to madness in the light of sin (Fotini, 1987, p.17): mental illness is the result of the individual's choice of 'evil'. In other words, it is a conscious choice to violate God's law, for which the individual is responsible, and for which he is often punished in the form of barbaric abuse, which is thus legitimised in the name of divine justice.

Following medieval notions, during the 15th century, eminent physicians (Paracelsus (1493-1541) and Johan Weyer (1516-1588) they no longer consider the mentally ill demon possessed, but sick. This nosological model of madness (Fotini, 1997, p. 37) will continue to be cultivated under the influence of the Enlightenment philosophers and reinforced by the prevailing rationality that will be the product of the industrial revolution. At the same time, there is a need to separate the "healthy" community from the mentally ill, the latter being considered parasites living at its expense a social problem facing their expulsion to remote areas, and later to penitentiary asylums and hospitals together with other social undesirables, criminals, unemployed, poor.

3. Stigma and mental illness

In Greek stigma means stain, stain, indelible mark, a sign by which society separates those who want to stigmatize them. Figuratively speaking, stigma is a highly derogatory term attributed to someone who is very hard to get rid of. It is the bad reputation and lack of moral worth that accompanies and is certainly borne by someone. It means anything that causes shame or social condemnation (abiniotis, 2002). In recent years, the word stigma has been used primarily to indicate that certain diseases, such as tuberculosis, cancer and especially mental illnesses, and the characteristics and behaviours that accompany them, raise prejudice against those who suffer from them (Economou-Lalioi, 2009, pp. 135-142).

The standard definition of stigma refers to loss of social status and discrimination resulting from a series of negative stereotypes about people who are stigmatised. In the process of stigmatisation, a particular human difference is associated with undesirable qualities according to prevailing social beliefs. These negative stereotypes, in turn, justify the separation and classification of 'designated individuals' into separate groups, accompanied by a loss of their social status ('damaged identity'), which also leads to similar discrimination. Stigma is not about acknowledging any functional deficiencies of the individuals who carry it, but is mainly about underestimating or even ignoring any benefits that might arise from treatment, and excluding them from the possibility of being tested, based on wrong assumptions (Andreou, 2004).

In trying to define the position, we always turn to Goffman's work. Many scholars have studied stigma, but Goffman is a touchstone as younger scholars begin their work on definitions of concepts and context of study. Goffman defines stigma as "a trait, deeply defamatory and undesirable," that deprives someone of the right to full social acceptance while forcing them to try, when possible, to hide the cause of this treatment, whereby the individual. is characterized as "from complete to tainted, incomplete." Or as "the relationship between trait and stereotype". Describe

the defense mechanisms developed by individuals who "carry" the stigma and especially the importance of "secrecy" in those who find the condition of mental illness humiliating (Goffman, 1963).

Despite the extreme positions that emerged in later years, on the one hand that the emergence of the mentally ill is a direct consequence of social reaction and on the other that "for the vast majority of the mentally ill the stigma is temporary and does not seem to cause many problems." . Most of the research has remained on extending how stigma affects the mentally ill and on recognising that stigma is not just a matter of acknowledging any functional deficiencies of those who 'carry' it. It is established in the underestimation of any benefit that might result from treatment and the exclusion of these individuals from the possibility of being tested, based on faulty assumptions (Goffman, 2001).

Dudley, working from Goffman's original conception, defines stigma as stereotypes or negative attitudes attributed to an individual or group of people when their characteristics or behaviours are considered different or inferior to social norms (Dudley, 2000).

In general, stigma is the negative evaluation of a person as being altered or devalued based on certain characteristics, which may be a mental disorder, ethnicity, drug use or a physical disability. It is the cause or negative effect of a 'label' capable of separating the individual from the rest of society. According to Goffman, this is the relationship between "a trait and a stereotype". Goffman's work has been described as profoundly insightful, among other things, because it was and is the constant point of reference for all researchers who often try to define stigma or define it conceptually. In 1963, Goffman spoke of two concepts, "own" and "wise". They are the stigmatized, while they are not the ones who know the stigma and accept it. In other words, today we would say that stigma exists in the "distance" between the stigmatized and the "stigmatizing". Subsequent and modern researchers of stigma tend to determine it in many ways, depending on the parameters they consider in each case. Among other things, stigma is the false and unjustified association of people with a mental illness, their families, their friends and the services they use with something shameful (Rosen et al, 2000).

Otherwise, stigma is defined as the combination of perceived danger and social distance (Zartaloudi et al, 2010). Stigma as a social concept contains the element of labelling and is associated with the rejection of deviant behaviour. It is something that accompanies a person and radically undermines his or her social position, an indelible sign of shame or worthlessness. Many people with severe mental disorders look different because of the symptoms or side effects of the drug. Others may notice differences, not understand them, feel uncomfortable and react negatively to them.

Despite the abundance of definitions that attempt to explain the meaning of stigma, the first step towards understanding it is the study of its components and, more importantly, the study of the process by which it originates and exists. The experience of mental illness is not limited to the symptoms of the illness, but is accompanied by what Finzen calls the 'second illness', i.e. the reactions of the social environment, prejudices and stereotypes that accompany the disorder, in contrast to the physical disorder. illnesses in which the social contract is accepted that the patient is not responsible for their condition (Finzen, 1996). Stigma distinguishes one as different from others, isolating one from the whole and leading to a loss of value. As a social construct it is observed in interpersonal relationships.

In the process of creating stigma, differences between people are highlighted. According to Lemert, the formal rendering of a divergent characteristic in the sense of a 'label' initiates the process of social stigmatisation due to deviation from social norms. The meaning of the label is directly imposed on the person through deviant behaviour, which is behaviour that has already been characterised by others (Lemert, 1951).

4. The modern age and the stigmatization of the mentally illness

Many studies have examined general public attitudes and perceptions of mental illness and social distance from the mentally ill (Huxley, 1993).

Public attitudes towards mental illness are negative: schizophrenics are seen as unpredictable, aggressive, dangerous, of low intelligence, lacking self-control and logic, and a large part of the population is opposed to the prospect of engaging in certain social relationships, such as with a person with schizophrenia, suggesting them for work or entrusting them with the care of their children (Angermeyer et al, 2004).

The characteristics of people with stereotype-based mental illness can be summarised as: sloppy appearance, irritable behaviour and low socio-economic status. Assumptions about the existence of mental illness are emphasised with emphasis on poor behaviour, incomprehensible acts and of course a history of involuntary hospitalisation, violent behaviour and criminality. Public information about mental disorder reflects a self-induced, untreatable chronic illness in which the patient must always take their medication to be well (Byrne, 2001)

At the same time, social stigma also includes psychiatrists. Social perceptions portray psychiatrists, at best, as eccentric individuals, who over time are influenced by their patients and at worst, emotionally exhausted and unable to help (Pidd, 2003).

In a study by Grisp et al (2000), conducted as part of a campaign to reduce the stigma of mental illness in a large UK population, found that 71.3% of participants considered patients with schizophrenia a threat to others and 77.3% unpredictable. 23% also considered patients with depression to be at risk, while 18.6% thought they should "seek recovery". It appears that the data leading to the formation and maintenance of negative attitudes are not yet clear and that these, from research to date, may include, in addition to lack of information, demographic factors and some types of contact (or lack thereof.) with people with mental illness (Grisp, 2000).

Many studies, both past and present, support the positive relationship between education and tolerance. Other studies have shown that despite public awareness campaigns about mental illness in the community, the position remains relatively unchanged (Papadopoulos, 2002, Phelan, 1998).

In terms of demographics, Hayward et al. In a review of the relevant literature, they report that older people, lower educational attainment, and lower professional and/or social status tend to maintain a more dismissive attitude. In a study conducted in Greece, similar findings emerged. A subsequent study of the general population in the Athens area, comparing a sample of 400 adults in 1979/80 and 1994 on the degree of social acceptance or rejection of people with mental illness, revealed more positive attitudes towards the social integration of the mentally ill in the second period. This was attributed to the improvement in the living conditions of the sample, the effort to promote psychiatric services to the public at the same time and the influences of social inclusion and deinstitutionalisation of the mentally ill. It is therefore possible that the correlation between

demographic factors and attitudes towards mental illness is an indirect effect of information on mental illness, i.e. it is not so much that demographic variables differentiate attitudes towards mental illness, but that they reflect the degree of information between in different social groups (Hayward, 1997).

5. Survey on the attitudes of Greek and Romanian residents to mental health.

In order to address the views of the people of Greece and Romania towards the mentally ill, we did a little research on people's views on mental illness. Although at first there were doubts whether respondents would answer such substantive questions and whether the results would have the validity and reliability of an organized survey, the survey was conducted and we believe that the overall picture of what residents believe was finally shaped by the imagination of the mentally ill.

The purpose of the research was to reveal through residents' social representations, their knowledge of mental illness, their attitudes towards a mentally ill person and the ways in which they treat them.

The research was carried out on a sample of 100 inhabitants from both countries, respectively 50 people from Greece and 50 people from Romania. Respondents were selected to ensure representation of different types of opinion. The choice of these inhabitants was partly random and partly deliberate. We were interested in the point of view of all people, regardless of their educational and financial level. That is why the respondents were farmers, workers, students, even people with higher education.

The questions focused on residents' views of mental illness and their daily relationship with the mentally ill. Residents were asked to respond based on what they knew, whether or not they had had some experience in their immediate environment. In this way, respondents gave explanations about the illness as well as the views they had adopted and managed their daily relationship with the mentally ill.

Table 1. Which of the following situations would you describe as belonging to the mentally ill category

	Romania	%	Grecia	%
Schizophrenia	16	32%	7	14%
Manic depression	4	8%	0	0%
Melancholia	2	4%	0	0%
Depression	4	8%	2	4%
Epilepsy	1	2%	0	0%
Anxious nervousness	2	4%	1	2%
Anorexia or psychogenic bulimia	1	2%	1	2%
All of the above	20	40%	39	78%

The data in Table 1 indicate that schizophrenia has a significantly higher prevalence in Romania (32%) than in Greece (14%). This could be influenced by several factors, including cultural differences, access to mental health services and different approaches to diagnosis.

Depression has a similar prevalence in both countries (8% in Romania and 4% in Greece). However, anxiety seems to be more common in Romania (4%) than in Greece (2%). This difference may be related to socio-cultural and economic factors, as well as to the

level of awareness and access to treatment for anxiety disorders.

Manic depression and melancholia appear to be rarer in both countries, and their proportions are small. However, these data reflect under-diagnosis or under-reporting of these conditions in certain cultural contexts.

The overall comparison "All of the above" accounts for a significantly higher proportion of mental health cases in Greece (78%) than in Romania (40%). This difference can be explained by the different diagnostic and treatment approaches used in the two countries.

The data suggest that mental health is a significant concern in both countries, with significant variations in the prevalence of different conditions. Differences in culture, socio-economics and health care systems may play an important role in these differences.

In conclusion, this analysis indicates that there is significant variability in the prevalence and distribution of mental health conditions between Romania and Greece.

Table 2. Awareness of mental illnesses

	România	La suta	Grecia	La suta
Schizophrenia	9	18%	3	6%
Manic depression	0	0%	1	2%
Melancholia	3	6%	2	4%
Depression	16	32%	23	46%
Epilepsy	0	0%	2	4%
Anxious nervousness	1	2%	2	4%
Anorexia or psychogenic bulimia	1	2%	1	2%
All of the above	20	40%	16	32%

In order to carry out a sociological analysis of the data related to the degree of information or awareness about mental illness in Romania and Greece, we will use the data provided to draw conclusions and better understand public perception (Table 2).

In Romania, 18% of respondents said they had been informed, heard or read about schizophrenia, while in Greece this percentage is 6%. This difference suggests that schizophrenia is better known or discussed in Romania than in Greece.

In Greece, there is lower awareness of manic depression and melancholia, with only 2% of respondents stating that they have heard of these conditions. In Romania, manic depression was not mentioned at all, and melancholia has a reporting of 6%. This may indicate a lack of awareness or an underestimation of these disorders in both countries.

Depression is the most common mental health condition in both countries, with 32% of respondents in Romania and 46% in Greece saying they had heard or read about it. This suggests that depression is a better known and discussed problem in Greece.

In Greece, 4% of respondents said they had heard of hysterical nerve or epilepsy, while in Romania this percentage was 0%. This may reflect differences in terminology or awareness of these conditions in the two countries.

Conditions such as anxious nervousness and psychogenic anorexia or bulimia are relatively unknown in both countries, with low awareness rates.

The data show that the level of awareness and information about mental health diseases varies significantly between the two countries. This may be influenced by education, awareness campaigns, stigma and access to information. It also points to the need to continue mental health education and awareness efforts in both countries.

Table 3. People's search preferences help for mental disorders

	România	%	Grecia	%
To the psychiatrist	25	50%	27	54%
he psychologist	14	28%	20	40%
The neurologist	5	10%	1	2%
At the family doctor	1	2%	0	0%
Friend	1	2%	0	0%
In a mental hospital	1	2%	0	0%
To a social worker	0	0%	1	2%
Nobody (I would have tried to manage it myself)	3	6%	1	2%

In order to conduct a sociological analysis of respondents' preferences and options for seeking help for symptoms of mental disorders, we can use the data provided to assess their behaviour and attitudes.

The majority of respondents in both countries indicate that they would seek help from mental health professionals when faced with symptoms of mental disorders. Psychiatrists and psychologists are the preferred options for this category of respondents. In Romania, 50% of respondents would seek the help of a psychiatrist, while in Greece the figure is 54%. Some 28% of respondents in both countries would see a psychologist.

Data indicate that mental health professionals, such as psychiatrists and psychologists, are seen as essential resources for the treatment and management of mental disorders. This reflects confidence in the competence of these specialists in diagnosing and treating mental health problems.

A small percentage of respondents would turn to other resources, such as a neurologist or social worker, for symptoms of mental disorders. However, these options are less popular than psychiatrists and psychologists.

A small number of respondents indicate that they would not turn to anyone and try to manage the symptoms of mental disorders on their own. This option may reflect a desire for independence or may indicate a lack of awareness of the importance of seeking professional help in such situations.

The data suggest that most respondents understand the importance of seeking professional help for symptoms of mental disorders. This reflects an increased awareness of the seriousness of mental health problems and the need for appropriate treatment. Psychiatrists and psychologists are seen as the main professionals who can provide such treatment.

However, it is important to continue mental health education and awareness efforts to reduce stigma and encourage people to seek help when needed.

Table 4. The influence of mental illnesses in the family environment

	Romania	%	Grecia	%
Almost daily	7	14%	8	16%
Enough	19	38%	31	62%
Little bit	17	34%	8	16%
Not at all	7	14%	3	6%

In order to carry out a sociological analysis of how the presence of a mentally ill person in the environment of family or friends can influence the personal life of the respondents, we can use the data provided to evaluate their reactions and perceptions.

The data indicate that a significant proportion of respondents in both countries believe that the presence of a mentally ill person in their family or friends environment has had a significant or fairly significant influence on their personal life. In Romania, 52% of respondents indicated that this influence was quite significant or almost daily, while in Greece this percentage is even higher, at 78%.

The majority of respondents in both countries report that the influence on their personal life was quite significant (38% in Romania and 62% in Greece). This suggests that the presence of a mentally ill person can have a significant impact on the personal lives of those around them.

However, there is also a minority percentage of respondents who believe that there has been little or no influence. This may reflect the variability of individual experiences and relationship dynamics in family and friend environments.

The data suggest that the presence of a mentally ill person in the environment of family or friends can have a significant impact on the personal life of the respondents. This impact can vary depending on the nature of the mental illness, the level of mental health awareness and the level of support provided to the affected person.

It is important to emphasize that mental disorders can affect the dynamics of interpersonal relationships and may impose additional responsibilities in caring for and supporting the affected person. Understanding and empathy are essential in such situations and the support provided can make a significant difference in the lives of those facing such challenges. It is also important to promote awareness and education about mental health to reduce stigma and provide adequate support to those who are affected.

Table 5. The influence of family medical history regarding mental illness on perception and attitudes

	Romania	%	Grecia	%
You would avoid talking about your problem	4	8%	1	2%
You would visit a specialist doctor	42	84%	43	86%
You would talk to your partner	4	8%	6	12%

In order to carry out a sociological analysis of how the presence of a person with a mental illness in the environment of family or friends can influence personal life, we can use the data provided to evaluate the reactions and attitudes of the respondents.

The predominant reaction in both countries is to visit a specialist doctor if someone in the family or friends environment is mentally ill. A significant percentage of respondents (84% in Romania and 86% in Greece) indicate that they would seek professional help to cope with the situation. This is a positive reaction, indicating the importance placed on mental health and the willingness to seek appropriate treatment and support.

A smaller percentage of respondents (8% in Romania and 12% in Greece) would choose to talk to their partner about the problem related to mental illness. This may suggest that some respondents prefer to share such problems with a trusted person, such as their partner, before seeking professional help or emotional support.

A small percentage of respondents (8% in Romania and 2% in Greece) would choose to avoid talking about the problem related to mental illness. This may reflect the stigma associated with mental health and the desire to remain silent about such issues.

The data indicate that most respondents would seek professional help and visit a specialist if someone in their family or friends had a mental illness. This suggests an increased awareness of the importance of mental health care and a desire to get appropriate help.

However, there is also a minority segment who would choose to avoid the discussion or discuss it with their partner. This may be influenced by factors such as stigma and personal preferences regarding communication about mental health.

It is important to promote understanding, openness and empathy towards people with mental illness in the environment of family and friends. It is also crucial to provide access to treatment and adequate support for those affected and to reduce the stigma associated with mental health.

Table 6. Reaction of the respondents in the situation where the partner he would confess that he suffered from a mental illness

	România	%	Grecia	%
You would have broken off the relationship	1	2%	1	2%
You would have continued the relationship	12	24%	11	22%
You would have been scared and would not have talked about it with anyone	2	4%	0	0%
You would have advised him to visit his doctor again	26	52%	24	48%
You would be worried that it wouldn't happen again	9	18%	14	28%

The most common reaction in both countries is to continue the relationship with the partner, with about a quarter of respondents (24% in Romania and 22% in Greece) indicating this option. This suggests that most respondents are willing to stay with their partner regardless of his or her history of mental illness.

A significant proportion of respondents (52% in Romania and 48% in Greece) would advise their partner to see a doctor again. This may indicate a concern for your partner's health and a desire to support them in their mental health care.

A significant number of respondents (18% in Romania and 28% in Greece) would be restless and worried that something will happen to their partner. This reaction may reflect concern for the partner's health and fear that symptoms of mental illness may recur.

A small proportion of respondents (2% in both countries) would end the relationship with their partner if they disclosed their history of mental illness. This indicates that for most respondents, a history of mental illness would not be a sufficient reason to end the relationship.

A small number of respondents (4% in Romania and none in Greece) would be scared and would not talk about their history of mental illness with anyone. This may reflect the stigma associated with mental health and the difficulty in discussing the issue openly.

In conclusion, the data (Table 6) suggest that the majority of respondents would be open to continuing their relationship with their partner and would advise their partner to see their doctor again if they disclosed their history of mental illness. This indicates a degree of understanding and support for mental health in couple relationships. However, there is also significant concern for the partner's health and some levels of anxiety and worry. It is important to promote openness and understanding regarding mental health in interpersonal relationships.

Table 7. Respondents' attitude towards working in the same place with a mentally ill person

	România	%	Grecia	%
Definitely yes	2	4%	1	2%
Of course not	15	30%	14	28%
Probably yes	4	8%	7	14%
Probably not	22	44%	22	44%
I do not know	7	14%	6	12%
I do not answer	0	0%	0	0%

The data in table 7 indicate that the majority of respondents in both countries have negative or reluctant attitudes towards working in the same place as a mentally ill person.

In Romania, 30% of respondents would say "Definitely not", and 44% answered "Probably not". In Greece, the same categories represent 28% and 44% of respondents, respectively.

However, there is a minority of respondents who would be willing to work alongside a mentally ill person. In both countries, approximately 10-12% of respondents answered "Definitely yes" or "Probably yes".

A small percentage of respondents (around 12-14%) in both countries do not know or did not answer this question, which may indicate uncertainty or lack of clarity in their views.

The data suggest that there is significant stigma and increased reluctance to work alongside a mentally ill person in the workplace. These attitudes can be influenced by factors such as stereotypes and prejudices about mental health, lack of information or previous experiences.

It is important to promote understanding and awareness of mental health in the workplace and to reduce the stigma associated with these issues. Education and awareness can help change attitudes and create a more inclusive and empathetic work environment for all employees, regardless of their mental health status.

Table 8. Employment of a person with mental illness

	România	%	Grecia	%
Definitely yes	9	18%	5	10%
Of course not	4	8%	2	4%
Probably yes	18	36%	18	36%
Probably not	9	18%	14	28%
I do not know	10	20%	10	20%
I do not answer	0	0%	1	2%

To carry out a sociological analysis of the question "As an employer, would you hire a person suffering from a mental illness?", we will use the data provided by the participants in this study, for Romania and Greece.

First, we can see that there is a variety of opinions among respondents in both countries regarding the employment of a person suffering from a mental illness.

"Definitely yes" answers represent a minority segment of respondents, with 18% in Romania and 10% in Greece. These employers are very open to hiring a person with a mental illness, which suggests an understanding and acceptance of diversity and inclusion in the workplace.

On the other hand, "Definitely not" answers represent a small percentage of the total, with 8% in Romania and 4% in Greece. These employers strongly oppose the idea of hiring someone with a mental illness, perhaps because of concerns or stigma surrounding the issue.

Most respondents appear to be in the "Probably Yes" or "Probably No" category, indicating some uncertainty or ambiguity about employing a person with a mental illness. These employers may be open to the idea, but have some reservations or want more information before making a decision.

It is also important to note that a significant number of respondents chose 'Don't know' or 'Don't answer'. This may indicate a lack of information or conviction about the issue, as well as a potential need for education and awareness of mental health in the workplace.

In conclusion, the data show that employers' opinion about hiring a person with a mental illness is varied, with varying degrees of acceptance, opposition or ambiguity. This sociological analysis can serve as a starting point for the development of employment policies and practices that promote inclusion and mental health in the workplace.

Table 9. Do you think that the number of institutions should be increased therapeutic for the mentally illness

	Romania	La suta	Grecia	La suta
Definitely yes	36	72%	47	94%
Of course not	2	4%	0	0%
Probably yes	7	14%	2	4%
Probably not	2	4%	0	0%
I do not know	3	6%	1	2%
I do not answer	0	0%	0	0%

First of all, we can observe (Table 9) that the majority of respondents in both countries seem to support the idea of increasing the number of therapeutic institutions for the mentally ill. This is evident in the

"Definitely yes" answers, which represent 72% of the respondents in Romania and 94% of those in Greece. These figures suggest a high level of acceptance and support for the development of these institutions in both countries.

We also note that a significant percentage of respondents in both countries chose the answer "Probably yes" (14% in Romania and 4% in Greece). This indicates an openness to the idea of increasing the number of therapeutic institutions, with some reserve or uncertainty.

There are also a small number of respondents who chose the answers "Definitely not" or "Probably not". These respondents, in general, express opposition or doubt about the need to increase the number of therapeutic institutions. However, their percentages are relatively small (4% or less), suggesting that these views are less common among the population.

Another aspect to consider is the small percentage of respondents who chose the "Don't know" or "No answer" options. This may indicate a lack of knowledge or information about the issue at hand, or may reflect a lack of belief or interest in the subject.

In conclusion, the data show that there is significant support for increasing the number of therapeutic institutions for the mentally ill in both countries, with the majority of respondents supporting this idea. However, there are also some voices expressing reservations or opposition, although they are in the minority. It is important to note that sociological analysis could also include investigating the reasons behind these views, as well as the possible social and political implications of such a change in the mental health care system.

Conclusions

There are significant variations in the prevalence and distribution of mental health conditions between Romania and Greece. For a deeper understanding and the development of effective mental health policies, more detailed investigation is needed, including additional sociological research and collaboration with mental health experts. This could help tailor mental health strategies to the specific needs of each country and reduce disparities in the provision of mental health services.

The data obtained highlight significant variations in the level of awareness and information regarding mental health diseases between Romania and Greece. These differences may be influenced by factors such as education, awareness campaigns, stigma and access to information. It also emphasizes the importance of continued mental health education and awareness efforts in both countries to reduce information gaps and improve public understanding of these conditions.

There is a significant understanding of the importance of seeking professional help for symptoms of mental disorders among respondents in both countries. Psychiatrists and psychologists are perceived as the main service providers in this area. However, it is vital to continue education and awareness efforts to reduce stigma and encourage people to seek help when needed, thereby helping to improve the mental health of the population.

The presence of a mentally ill person in the environment of family or friends can have a significant impact on the personal life of the respondents. This impact can vary depending on individual and circumstantial factors, highlighting the complexity and importance of addressing mental health in society.

There is a variety of reactions and attitudes among respondents regarding the presence of a person with a mental illness in their environment. Understanding, education and appropriate support are essential to improve the management and care of mental health in these situations.

Most respondents would be willing to continue their relationship with their partner and would advise their partner to see their doctor again if they disclosed their history of mental illness. This indicates a degree of understanding and support for mental health in couple relationships. However, there is also significant concern for the partner's health and some levels of anxiety and worry. It is important to promote openness and understanding about mental health in interpersonal relationships to create an environment of appropriate support and understanding.

Education and awareness can help change attitudes and create a more inclusive and empathetic work environment for all employees, regardless of their mental health status.

There is a wide range of opinions and attitudes of employers towards employing people with mental illness. This sociological analysis provides a starting point for developing employment policies and practices that promote inclusion and mental health in the workplace.

The data obtained highlight significant support for increasing the number of therapeutic institutions for the mentally ill in both countries, with the majority of respondents supporting this idea. However, there are also some voices expressing reservations or opposition, although they are in the minority. Further analysis is important to better understand the reasons and implications of these views and to develop appropriate policies and practices in mental health care.

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