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Microaggression Towards Mental Illness and Related Factors

Ruhsal Hastalıklara Yönelik Mikroagresyon ve İlişkili Faktörler

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Abstract

Microaggressions against individuals with mental illness represent a pervasive form of discrimination that negatively impacts individuals' mental health and well-being. These microaggressions, defined as brief and commonplace verbal, behavioural, or environmental indignities, often convey derogatory messages to marginalized groups, including those with mental health issues. The subtle yet damaging nature of these interactions can lead to profound psychological consequences, including increased anxiety, depression, and social isolation. Understanding the societal and cultural contexts that shape these experiences is essential for developing effective interventions that address the unique needs of individuals with mental illness. In this context, this study, planned as a descriptive and cross-sectional research design, aimed to determine the levels of microaggression and the affecting factors towards individuals with mental illness in the general population. This cross-sectional study was conducted with 312 individuals using purposive sampling method over the age of 18 who were reached via an online questionnaire and agreed to participate in the study. Data were collected by sociodemographic data form, Religious Worldview Scale, Ethnocultural Empathy Scale, Microaggressions Towards Mental Illness Scale. As a result of the regression analysis, female gender, high economic status, and religious beliefs were found to be significant predictors of microaggression towards mental illnesses.

Keywords

Microaggression, mental health, empathic awareness, religious worldview, cultural differences.

Öz

Ruhsal hastalığı olan bireylere yönelik mikro saldırılar, bireylerin ruh sağlığını ve iyilik halini olumsuz etkileyen yaygın bir ayrımcılık biçimini temsil eder. Kısa ve sıradan sözlü, davranışsal veya çevresel aşağılamalar olarak tanımlanan bu mikro saldırılar, ruh sağlığı sorunları olan bireyler de dahil olmak üzere marjinal gruplara genellikle aşağılayıcı mesajlar iletir. Bu etkileşimlerin incelikli ancak zarar verici doğası, artan kaygı, depresyon ve sosyal izolasyon gibi derin psikolojik sonuçlara yol açabilir. Bu deneyimleri şekillendiren toplumsal ve kültürel bağlamları anlamak, ruhsal hastalığı olan bireylerin benzersiz ihtiyaçlarını ele alan etkili müdahaleler geliştirmek için esastır. Bu bağlamda tanımlayıcı ve kesitsel bir araştırma deseni olarak planlanan bu çalışma, genel toplumda ruhsal hastalığı olan bireylere yönelik mikro saldırganlık düzeylerini ve etkileyen faktörleri belirlemek amacıyla yapılmıştır. Kesitsel tipteki bu çalışma, çevrimiçi anket yoluyla ulaşılan ve çalışmaya katılmayı kabul eden 18 yaş üstü 312 bireyle amaçlı örnekleme yöntemi kullanılarak yürütülmüştür. Veriler sosyodemografik veri formu, Dini Dünya Görüşü Ölçeği, Etno kültürel Empati Ölçeği, Ruhsal Hastalıklara Yönelik Mikro Saldırganlık Ölçeği kullanılarak toplanmıştır. Yapılan regresyon analizi sonucunda kadın cinsiyet, yüksek ekonomik durum ve dini inançların ruhsal hastalıklara yönelik mikroagresyonun önemli birer yordayıcısı olduğu bulunmuştur.

Anahtar Kelimeler

Mikroagresyon, ruh sağlığı, empatik farkındalık, dini dünya görüşü, kültürel farklılıklar.

Introduction

Microaggressions against individuals with mental illness represent a pervasive form of discrimination that negatively impacts individuals' mental health and well-being. These microaggressions, defined as brief and commonplace verbal, behavioural, or environmental indignities, often convey derogatory messages to marginalized groups, including those with mental health issues (Barber et al., 2019). The literature indicates that microaggressions can manifest in various forms, including microinvalidations, assumptions of inferiority, and assumptions of dangerousness, which collectively contribute to a hostile environment for individuals with mental illness (Gonzales et al., 2015). The psychological consequences of such microaggressions are profound, leading to increased feelings of anxiety, depression, and social isolation among affected individuals (Sisselman-Borgia et al., 2021).

1. Literature Review

Research has shown that the endorsement of microaggressions towards individuals with mental health issues is often influenced by broader societal attitudes, including political views and socioeconomic factors. For instance, individuals with right-wing political beliefs and those from socioeconomically disadvantaged backgrounds are more likely to endorse microaggressions against people with mental health problems (Barber et al., 2019). This correlation suggests that microaggressions are not merely individual acts of prejudice but are embedded within larger societal structures that perpetuate stigma and discrimination against mental illness (O'Connor et al., 2018). Furthermore, the intersectionality of identity—where individuals may simultaneously belong to multiple marginalized groups—can exacerbate the experience of microaggressions, leading to compounded psychological distress (Park et al., 2023).

The role of cultural context in shaping the experience of microaggressions towards mental illness cannot be overlooked. In collectivist cultures, for example, the stigma associated with mental illness may be particularly pronounced, as individuals may feel a heightened sense of shame or responsibility towards their families and communities (Ma et al., 2022). This cultural dimension can complicate the recovery journey for individuals with mental illness, as they may face additional pressures to conform to societal expectations while grappling with their own mental health challenges (Park et al., 2023). Understanding these cultural nuances is essential for developing effective interventions that address the unique needs of diverse populations (Zoubaa et al., 2020).

The implications of microaggressions extend beyond individual experiences; they also have broader societal consequences. The normalization of microaggressions in everyday interactions can perpetuate stigma and reinforce negative stereotypes about mental illness, ultimately shaping public perceptions and policies related to mental health (Vaccaro et al., 2018). This societal dimension highlights the need for comprehensive strategies aimed at reducing microaggressions and promoting mental health awareness (Fong & Mak, 2022). Educational initiatives that raise awareness about the impact of microaggressions and foster empathy towards individuals with mental illness can play a vital role in mitigating these harmful behaviours (Conover & Israel, 2019).

Microaggressions towards individuals with mental illness represent a significant barrier to mental health and well-being. The subtle yet damaging nature of these interactions can lead to profound psychological consequences, including increased anxiety, depression, and social isolation. Studies examining microaggressions towards mental illnesses are limited in the literature. microaggressions related to mental illness significantly affect individuals' perceptions of their mental health and willingness to engage with treatment (Gonzales 2022; Fong & Mak, 2022). Understanding the societal and cultural contexts that shape these experiences is essential for developing effective interventions that address the unique needs of individuals with mental illness. By fostering awareness and empathy, society can work towards reducing the prevalence of microaggressions and creating a more inclusive environment for all individuals, regardless of their mental health status. In conclusion, the literature underscores the significant negative impact of microaggressions on mental health, particularly among marginalized groups. The interplay of various forms of microaggressions—whether related to race, sexual orientation, or mental health status—creates a complex landscape of psychological distress that warrants further exploration. Addressing these subtle forms of discrimination is crucial for improving mental health outcomes and fostering a more inclusive society.

In this context, this study, planned as a descriptive and cross-sectional research design, aimed to determine the levels of microaggression and the affecting factors towards individuals with mental illness in the general population.

2. Methods

2.1. Design

This study was conducted in a descriptive and cross-sectional online survey was used to determine the levels of microaggression and the affecting factors towards individuals with mental illness in the general population.
Independent variables: Sociodemographic characteristics, ethnocultural empathy level, religious view level.
Dependent variable: The level of microaggression against mental illness.

2.2. Participants

The present study was conducted in March-June 2024 with 312 individuals who agreed to participate. The participants were recruited through purposive sampling, using an online survey distributed via social media. Individuals who saw the advertisement for the study, agreed to participate, and met the inclusion criteria formed the sample. Inclusion criteria as below: (1) being over 18 years old, (2) independence in individual decision-making, (3) having not diagnoses for mental illness. The exclusion criteria as below (1) being under 18 years of age and (2) being illiterate. An a priori power analysis was conducted using G*Power to determine the required sample size for detecting a medium effect size in a study. These results suggest that a total sample size of 280 participants is necessary to achieve a power of 0.95 for detecting the specified effect size with a significance level of 0.05. Considering a potential data loss of 20%, the adjusted total sample size required to maintain the desired power is approximately 350 participants. The sample consisted of individuals who responded to the online survey during the data collection period, saw the study advertisement, and met the inclusion criteria (n=312). The post hoc power analysis revealed that with a total sample size of 312 participants, the study achieves a power of approximately 0.97.

2.3. Measures

Data were collected by sociodemographic data form, Religious Worldview Scale, Ethnocultural Empathy Scale, Microaggressions Towards Mental Illness Scale.

2.3.1. Sociodemographic Data Form

The form, prepared by researchers in line with the literature, consists of a total of 13 questions such as the patient's gender, age, marital status, educational status, geographical region, living area, mother education status, father education status, knowing someone with a psychological disorder, and economic status.

2.3.2. Religious Worldview Scale (RWVs)

The scale was developed by Goplen and Plant (2015) to determine religious worldviews. The scale consists of 19 items answered on a 5-point Likert type (1-I completely disagree, 5-I completely agree). The Turkish validity and reliability of the scale was done by Kuşat and Bulut in 2016. The scale consists of 2 sub-dimensions: making sense of the afterlife and making sense of this world. As the score obtained from the scale increases, the effect of religion on the person's making sense of the world increases. In this study, the Cronbach alpha coefficient of the scale was found to be.79.

2.3.3. Scale of Ethnocultural Empathy (SEE)

It was developed by Wang et al. (2003) to determine the level of ethnocultural empathy in different ethnic groups (Wang et al., 2003). The Turkish validity and reliability study was conducted by Özdikmenli and Demir (2014). The original scale has 6 grades, and in the version used in Turkey, it was used as 5 grades, and its validity and reliability were tested. The original form of the scale consists of 31 items, and the Turkish version consists of 30 items and 3 sub-dimensions, respectively: 1. empathic feeling and expression, 2. empathic perspective taking and acceptance of cultural differences, and 3. empathic awareness. A total ethnocultural empathy score can be obtained from all items of the scale. Increasing scores indicate a higher level of ethnocultural empathy. In this study, the internal consistency coefficient of the scale was found to be .71.

2.3.4. Mental Illness Micro-Aggression Scale-Perpetrator Version (MIMS-P)

It was developed by Gonzales et al. (2015) to measure microaggression towards individuals with mental health disorders. The scale contains 17 items regarding microaggression attitudes towards individuals with mental illness. Each statement is rated from 1 to 4. The scale consists of 4 sub-dimensions, which are respectively: Protection, Inadequacy, Inferiority Assumption, Fear

of Mental Illness (Gonzales et al., 2015). The Turkish validity and reliability of the scale was made by Ertem and Karakaş (2022). As the total score obtained from the scale increases, microaggression attitude also increases (Ertem & Karakaş 2022). In this study, the internal consistency coefficient of the scale was found to be.84.

2.4. Data Analysis

The data were analysed using the IBM SPSS 29.0 programme (Statistical Package for the Social Sciences). Descriptive statistics were used for the Socio-demographic characteristics and the mean value of the participants' scales. Whether the participants' microaggression levels varied according to sociodemographic characteristics was tested using independent groups t test and One Way Anova test. Correlation and regression analyses were used to determine the relationship between the variables. A correlation criterion that is considered acceptable is set at more than 0.30 points. The test statistics for interpreting the correlation coefficients were performed successfully. Poor (0.00-0.20), Medium (0.21-0.40), Good (0.41-0.60), Very Good (0.61-0.80) and Excellent (0.81-1.00) are the available quality levels (Mukaka, 2012).

2.5. Data Collection

The data were collected based on self-reporting using an online questionnaire. Ethical approval was obtained from the ethics committee of the institution where the researcher worked (Date: 23.03.2024; Number:2024/17). When the online questionnaire for data collection was prepared, the participants were informed in accordance with Articles 6, 7, 8, 9 and 12 of the "Law on the Protection of Personal Data No. 6698" and the participants whose consent was obtained completed the questionnaire. On the first page of the questionnaire, the contact details of the researcher were provided so that participants who wished to ask questions or exchange views could do so. Due to the anonymous nature of the responses, participants could not withdraw their responses once the survey was completed. All participants with missing data were excluded from the study (n = 12), and all responses were screened for inconsistencies prior to analysis to minimize the risk of fraud. To prevent repeated responses, an account login requirement was introduced, and responses were limited to one response from the same account.

3. Results

3.1. Characteristics of Participants

The characteristics of the participants were shown in Table 1. 312 people over the age of 18 participated in the study. The mean age of the participants was 27.47±6.88(min:18-max:62). Of the participants, 66.7% were male and 75.3% lived in the Eastern Anatolia region. 64.1% had an associate degree or bachelor's degree. 85.6% lived in the city. 62.2% did not have acquaintances with mental disorders. The average score of the participants' religious worldviews was found to be 63.94±9.56 (min:23-max:87). A minimum of 19 and a maximum of 95 points can be obtained from the Religious Worldviews scale. It can be said that the participants' religious beliefs are at a high level in making sense of life. In addition, the participants' ethnocultural empathy levels were found to be 93.50±7.34 (min:65-max:117). A minimum of 30 and a maximum of 150 points can be obtained from the Ethnocultural Empathy Scale. It can be said that the participants' ethnocultural empathy levels are above average.

Table 1. Socio-demographic Characteristics of Participants

VARİABLES		
	M±SD	**Min- Max**
Age (Years)	*27.47±6.88*	18-62
	N/	**%**
Gender		
Male	208	66.7%
Female	104	33.3 %
Education Level		
Primary school/Secondary school	22	7.1 %
High school	51	16,3%
Associate degree/Undergraduate	200	64.1%
Postgraduate	39	12.5%
Geographical region you live in		
Eastern Anatolia	235	75.3%
Central Anatolia	3	1 %

Aegean	8	2.6 %
Southeast	32	10.3 %
Mediterranean	7	2.2 %
Black Sea	5	1.6%
Marmara	22	7.1%
Living area		
Urban	267	85.6%
Rural	45	14.4%
Mother Education		
Illiterate	143	45.8%
Primary school graduate	108	34.6%
Secondary school graduate	25	8%
High school graduate	23	7.4%
University graduate	13	4.2 %
Father Education		
Illiterate	48	15.4%
Primary school graduate	125	40.1%
Secondary school graduate	68	21.8%
High school graduate	38	12.2%
University graduate	33	10.6%
Marital status		
Married	77	24.7%
Single	195	62.5%
I have a partner	40	12.8 %
Economic situation		
Income less than expenses	98	31.4%
Income equal to expenses	168	53.8%
Income more than expenses	46	14.7%
Do you know anyone with a mental disorder?		
Yes	118	37.8%
No	194	62.2%
Scales	**M±SD**	**Min- Max**
Religious Worldview Scale	63.94±9.56	23-87
Ethnocultural Empathy Scale	93.50±7.34	65-117

M: Mean; SD: Standard Deviation.

3.2. The Level of Microaggression Towards Mental Illness of Participants

Table 2 show that the mean score of the mental illness microaggressions scale-perpetrator version (MIMS-P) of participants.

Table 2: The mean score of the MIMS-P of participants.

	Minimum	Maximum	Mean	SD
MIMS-P Total Score	1.00	3.76	2.49	.40
Protection	1.00	4.00	2.70	.52
Inadequacy	1.00	4.00	2.45	.53
Inferiority Assumption	1.00	4.00	2.34	.44
Fear of Mental Illness	1.00	4.00	2.42	.58

The mean score of the mental illness microaggressions scale-perpetrator version (MIMS-P) of participants was 2.49±.40. It can be said that the participants' micro aggressive attitudes towards mental illnesses are above average. While the participants' protection sub-dimension mean score (2.70±.52) is the highest, the inferiority assumption sub-dimension mean score (2.34±.44)

is the lowest.

3.3. Related Factors of the Microaggressions towards Mental Illness

According to the results of the analysis to examine whether the mental illness microaggression levels of the participants differ according to their individual characteristics shown in Table 3, it was observed that there was no significant difference between the gender, living area and geographical area of the participants and their mental illness microaggression levels.

The mean score of the protection subscale of MIMS-P of participants who high school graduate were observed higher as compared to participants who have undergraduate diploma (F:4.277; p:.015). In the other groups, there were no significant association the mean score of other subscales and MIMS-P total and education status. Moreover, the mean score of the inadequate subscale of the MIMS-P of married participants were found higher as compared to single and having relation (F:4.043; p:.018).

It was also found that the means score of the protection subscale of the MIMS-P was lower participants who income more than expenses compare to others (F:4.566, p:.011). The mean score of the inadequacy subscale of the MIMS-P of the participants who have relatives having mental illness lower than participants not having relatives having mental illness (t: -2.285; p:.023). Moreover, there were positively significant relationship found between religion levels of participants and the mental illness microaggression levels (p<0.001). Age of the participants was negatively correlated with the mean score of the fear of mental illness subscale of the MIMS-P. The level of ethnocultural empathy positively corelated to the mean score of the protection subscale of the MIMS-P and Total score of the MIMS-P.

Table 3: The Differentiation of the Mean Score of the MIMS-P According to the Socio Demographic Characteristics

	Protection	Inadequacy	Inferiority Assumption	Fear of Mental Illness	MIMS-P Total
Gender					
Female	2.77± .54	2.50±.54	2.41±.47	2.42±.61	2.54±.43
Male	2.67±.51	2.42±.53	2.31±.42	2.42±.56	2.46±.39
t/p	-1.570 .117	-1.301 .194	-1.907 .057	-.046 .964	-1.625 .105
Cohen d	.52	.53	.44	.58	.40
Education status					
Highschool[a]	2.86±.55	2.57±.57	2.42±.48	2.50±.61	2.60±.42
Undergraduate[b]	2.66±.49	2.41±.50	2.33±.42	2.43±.56	2.46±.38
Graduate[c]	2.62±.57	2.41±.61	2.28±.45	2.24±.56	2.40±.46
F/p	**4.277** **.015** **a>b**	2.414 .091	1.631 .197	2.563 .079	**3.929** **.021** **a>b,c**
(η^2)	**.027**	.015	.010	.016	**.025**
Marital status					
Married[a]	2.72±.54	2.59±.53	2.39±.46	2.37±.61	2.53±.44
Single[b]	2.72±.51	2.41±.49	2.33±.40	2.45±.53	2.49±.35
Having relation[c]	2.62±.56	2.33±.69	2.30±.58	2.38±.74	2.42±.55
F/p	.584 .558	**4.043** **.018** **a>b,c**	.688 .503	.728 .484	1.050 .351
(η^2)	.004	**.026**	.004	.005	.007
Economic status					
Income less than expenses[a]	2.75±.57	2.46±.52	2.37±.49	2.44±.58	2.51±.41
Income equal to expenses[b]	2.73±.48	2.46±.54	2.35±.42	2.44±.59	2.51±.39
Income more than expenses[c]	2.49±.52	2.36±.56	2.26±.43	2.34±.56	2.37±.40

F/p	**4.566** **.011** **a>c; b>c**	.616 .541	.886 .413	.599 .550	2.397 .093
(η^2)	**.029**	.004	.006	.004	.015
Geographical Area					
Other side Turkey	2.61±.49	2.35±.57	2.29±.45	2.44±.56	2.43±.39
Eastern Turkey	2.74±.53	2.48±.52	2.36±.44	2.42±.58	2.51±.41
t/p	-1.850 .065	-1.768 .078	-1.206 .229	.321 .748	-1.557 .120
Cohen d	.52	.53	.44	.58	.40
Living Area					
Urban	2.69±.51	2.46±.53	2.34±.44	2.42±.58	2.48±.40
Rural	2.78±.57	2.38±.58	2.38±.48	2.45±.56	2.51±.45
t/p	-1.009 .314	.911 .363	-.605 .546	-.396 .692	-.394 .694
Cohen d	.52	.53	.44	.58	.40
Having close someone with mental illness					
Yes	2.64±.59	2.36±.56	2.30±.45	2.40±.60	2.43±.45
No	2.74±.48	2.50±.51	2.37±.43	2.43±.56	2.52±.37
t/p	-1.493 .137	**-2.285** **.023**	-1.367 .173	-.419 .676	-1.769 .078
Cohen d	.52	**.53**	.44	.58	.40
Age	r: -.032;	r:.090	r:-.001	**r:-.119***	r:-.015
Religion	**r:.397****	**r:.415****	**r:.303****	**r:.263****	**r:.443****
Ethnocultural empathy	**r:.189****	r:.087	r:.031	r:.015	**r:.113***

η^2: Eta Squared, t: independent sample t test, F: One Way Anova, r: Pearson Correlation Coefficient

A forward stepwise linear regression was used to identify possible predictors of the microaggression against mental illness out of the following candidate variables: ***age, marital status, gender, education status, economic status, having close someone with mental illness, the level of religion view and the level of ethnocultural empathy.*** At each step, variables were added based on p-values, and the AIC was used to set a limit on the total number of variables included in the final model. (See in Table 4). In the first step the level of religious view was entered into model, resulting in a significant improvement ($F_{1,310}$=75.860; p<0.001). In the second step female gender was added leading to another significant enhancement ($F_{2,309}$=41.236; p<0.001). In the third step economic status was added leading to another significant enhancement ($F_{3,308}$= 29.811; p<0.001). The final model including the level of religious view, female gender and economic status demonstrated a strong fit accounting for a substantial proportion of a variance in the level of microaggression against mental illness (R2=.225; adjusted R2=.217).

Table 4. The Results of the Stepwise Multiple Regression Analysis

Model Summary									
					Change Statistics				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.443[a]	.197	.194	6.23146	.197	75.860	1	310	<.001
2	.459[b]	.210	.205	6.18821	.014	5.348	1	309	.021
3	.474[c]	.225	.217	6.14007	.015	5.864	1	308	.016
a. Predictors: (Constant), The level of religious view									
b. Predictors: (Constant), The level of religious view, female gender									
c. Predictors: (Constant), The level of religious view, female gender, Economic status (Income more than expenses)									

Table 5: The Coefficients of Model

Model	**B**	**Std. Error**	**β**	**t**	**Sig.**	**95%CI**	**F**

1	(Constant)	21.804	2.388		9.129	<.001	17.105-26.504	75.860
	The level of religious view	.322	.037	.443	8.710	<.001	.249-.394	
2	(Constant)	20.926	2.402		8.712	<.001	16.200-25.652	41.136
	The level of religious view	.326	.037	.450	8.886	<.001	.254-.399	
	Gender (female vs male)	1.721	.744	.117	2.313	.021	.257-3.186	
3	(Constant)	21.404	2.391		8.950	<.001	16.698-26.110	29.811
	The level of religious view	.323	.036	.445	8.859	<.001	.251-.395	
	Gender (female vs male)	1.983	.746	.135	2.657	.008	.515-3.452	
	Economic status (Income more than expenses)	-2.402	.992	-.123	-2.422	.016	-4.354--.450	

a. Dependent Variable: **MIMS-P**: Mental Illness Microaggression Scale-Perpetrator Form

4. Discussion

The current study of microaggressions towards mental illness within the general population of Turkey is of paramount importance, particularly in light of the increasing recognition of mental health issues and the stigma that often accompanies them. Microaggressions, defined as subtle, often unintentional, discriminatory comments or behaviours, can significantly impact individuals with mental health conditions, exacerbating feelings of isolation and distress. In Turkey, where cultural attitudes towards mental illness can be particularly stigmatizing, understanding the prevalence and nature of these microaggressions is critical for developing effective interventions and support systems.

In this study conducted with 312 participants, more than half of the participants were male and 75.3% lived in the Eastern Anatolia region. More than half of the participants (64.1%) had an associate degree or bachelor's degree, and the majority were single. According to the data of the Turkish Statistical Institute, the rate of individuals with an associate degree or bachelor's degree in the population aged 25 and over is 24.6% (Turkish Statistical Institute (TUIK), 2024). It is thought that the fact that participation in online studies is more common among people with a higher level of education has an impact on this result. It was determined that the participants' religious worldview score average was above average. As the score obtained from the scale increases, the effect of religion on the person's meaning of the world increases. It can be said that the participants' religious beliefs are at a high level in making sense of life. In addition, the participants' ethnocultural empathy levels are above average. Increasing scores indicate a high level of ethnocultural empathy. Similar to our findings, a study conducted at Linkoping University in Sweden among a sample of 365 undergraduate students at the beginning and end of four health field master's programs (medicine, psychology, nursing, and social work) found high levels of ethnocultural empathy (Rasoal et. all., 2009). In a study conducted in Indonesia, participants who had interaction experiences with people from different backgrounds were found to have high levels of ethnocultural empathy. (Taufik, 2019). The study, which included 469 undergraduate students (353 females and 116 males) from a public university in Northern California, revealed that higher levels of ethnic identity and empathy were positively associated with higher levels of ethnocultural empathy (Haro, 2016). In our study, the vast majority of the participants were individuals living in the Eastern Anatolia region. Like many other countries in the world, Turkey, with its young and growing population, suffers from ethnic discrimination and prejudice. In addition to the majority ethnic group, the Turks, there are more than 20 million Kurds, Zazas, Arabs, Armenians, Circassians and other groups living in the country, making up a quarter of the total population (Ethnic Population Distribution; http://ethnology.blogspot.com/).It is thought that the fact that the majority of the individuals participating in the study were from the Eastern Anatolia Region and that the majority of the people living in the Eastern Anatolia Region had an ethnic minority identity such as Kurd or Alevi was effective in this result. Culture can affect the way people think and behave, and it suggests that individuals living in the same region will exhibit common behaviours.

The average score of the participants on the Mental Illness Microaggression Scale-Perpetrator Version (MIMS-P) is 2.49. As the total score obtained from the scale increases, the microaggressive attitude also increases. While the participants' protection sub-dimension mean score was the highest, the inferiority assumption sub-dimension mean score was the lowest. It is thought that the high protection sub-dimension mean score of the participants may be due to the society's belief that individuals with mental health disorders should be monitored and that they need help from the environment. In parallel with our study, Ertem & Karakaş (2022) found the MIMS-P mean score to be 2.40 in their MIMS-P validity and reliability study with nursing students (Ertem & Karakaş 2022). Gonzales et al. (2015) found the MIMS-P mean score to be 2.21 in their study, but Gonzales et al. found the highest value in the fear of mental illness sub-dimension and the lowest value in the inadequacy sub-dimension in the MIMS-P sub-dimensions (Gonzales et.all.,2015). It is thought that the different results of the sub-dimensions in our study may be due to the study being conducted in a different culture and population. Participants who graduated from high school had higher MIMS-P scale mean scores compared to participants with other education levels. Studies have consistently shown that

individuals with lower levels of education tend to harbor more negative attitudes towards mental illness. For instance, Yuan et al. found that lower education levels were consistently linked to negative attitudes towards mental illness across various demographic factors, suggesting that education plays a critical role in shaping perceptions and reducing stigma (Yuan et al., 2016). Researches also indicated that individuals with lower levels of education tend to exhibit higher levels of stigma towards mental illness, which can manifest as discrimination in various settings including workplaces and educational institutions (Tumin et al., 2021; Zieger et al., 2016). This stigma can be attributed to a lack of mental health literacy, which is often correlated with educational attainment. Lower literacy rates can hinder individuals' ability to access and understand information about mental health, thereby perpetuating misconceptions and negative stereotypes (Lincoln et al., 2015; Girma et al., 2013).

In addition, the mean scores of the MIMS-P inadequacy subscale of married participants were found to be higher than those of single and coupled participants. Married participants tend to see individuals with mental health disorders as less inadequate. Research indicates that marital status can play a significant role in shaping attitudes towards mental illness. For instance, a study by Meng et al. found that single individuals often exhibited more positive attitudes towards mental disorders compared to their married counterparts, suggesting that marital status may influence perceptions of mental health (Meng et al., 2022). Marital status does appear to affect the microaggressions directed towards individuals with mental illness, although the relationship is complex and influenced by multiple factors. While some studies suggest that being married may correlate with more tolerant attitudes, others indicate that single individuals may be more accepting.

In the current study, participants with lower economic status tend to have more protective attitudes towards individuals with mental disorders. Research indicates that individuals from lower socioeconomic backgrounds often face increased stigma and microaggressions related to mental health. For instance, Barber et al. conducted a scoping review that highlighted a positive association between socioeconomic disadvantage and the endorsement of microaggressions towards people with mental health problems (Barber et al. 2019). This suggests that individuals in economically disadvantaged situations may be more likely to express negative attitudes and engage in microaggressive behaviours towards those with mental illness, potentially due to a lack of understanding or exposure to mental health issues. Conversely, the findings from Gür and Küçük indicate that individuals who perceive their economic status as good may exhibit more negative attitudes towards mental illness compared to those who view their economic status as poor or average (Gür & Küçük, 2016). This paradox suggests that economic security may lead to a sense of superiority or detachment from the struggles faced by those with mental health issues, fostering microaggressions. As the education and sociodemographic levels decrease, the approach towards these individuals may become more negative. It is known that individuals with lower economic levels, in particular, face mental illnesses more helplessly, see them as dangerous and have negative beliefs. However, it is known that individuals with middle economic levels have more positive attitudes and behaviours towards individuals with mental illnesses compared to individuals with higher economic levels (more fear and exclusion) (Baysal Doğanavşargil, 2013; Çam & Bilge, 2011; Çam & Bilge, 2013; Şen et al., 2003; Taşkın et al., 2002).

Participants with relatives who have mental illness have more positive attitudes towards mental illness. The mean score of the MIMS-P disability subscale was found to be higher in participants who did not have relatives with mental illness. In one study, individuals who were particularly familiar with individuals with mental health disorders through education or experience with family members and peers were less likely to endorse prejudicial attitudes toward individuals with mental health disorders, similar to our study (Corrigan et al., 2001). In a study examining microaggressions toward older individuals, it was found that those who committed microaggressions were not families but service providers and strangers (Geitzen et al., 2023). Individuals who have a longer history with individuals with mental illness (e.g. family members) may exhibit more positive attitudes due to knowledge of the illness and the ability to manage the problematic behaviours of the individual. In some studies, the ‘perpetrators’ of microaggressions toward individuals with mental illness were found to be largely family, friends, and healthcare professionals (Barber et al., 2019). Generally, when an individual is diagnosed with a mental illness, regardless of their characteristics, they are approached with prejudice and a tendency to exclude this individual from society may arise (Klaríc & Lovríc, 2017).

As the participants' ages increase, the MIMS-P scale fear of mental illness sub-dimension scores decrease. The endorsement of microaggressions is influenced by various demographic factors, including age. Conversely, research has demonstrated that younger individuals may exhibit different levels of awareness and sensitivity to microaggressions compared to older adults, potentially due to varying socialization experiences and exposure to discussions about mental health and discrimination (Barber et al., 2019). It is thought that fear of mental illnesses is affected by the level of knowledge and experiences, and therefore, higher levels of fear are experienced in young adults. As participants' religious belief levels increase, microaggression levels towards individuals with mental health disorders increase. The intersection of religion and microaggressions towards individuals with mental illness is a nuanced area of study that reveals how religious beliefs and practices can shape perceptions and treatment of mental health issues. The influence of conservative religious beliefs can exacerbate microaggressions against individuals with mental illness. For example, in communities where mental illness is viewed through a religious lens—often as

a result of sin or moral failing—individuals may face increased microaggressions from peers and family members (Sorrell et al., 2023). A study found that a significant portion of Qatari Muslim university students believed that mental illness is a punishment from God, reflecting a broader cultural narrative that associates mental health struggles with moral or spiritual shortcomings (Zolezzi et al., 2017). The research conducted among Muslims in 16 Arab countries that mental illness stigma was a modifiable individual factor that seems to strengthen the direct positive effect of religiosity on help-seeking attitudes (Fekih-Romdhane et al., 2023).

It was observed that as the participants' ethnocultural empathy levels increased, their protective attitudes towards individuals with mental health disorders also increased. The relationship between ethnocultural empathy and microaggressions towards individuals with mental illness is an important area of inquiry that highlights how cultural understanding and sensitivity can mitigate or exacerbate experiences of discrimination. Ethnocultural empathy, defined as the ability to empathize with individuals from different racial and ethnic backgrounds, plays a critical role in shaping attitudes and behaviours towards those with mental health challenges. Research indicates that higher levels of ethnocultural empathy can lead to a reduction in the endorsement of microaggressions. For instance, studies have shown that educational interventions aimed at increasing ethnocultural empathy among students can significantly decrease prejudicial attitudes and behaviours towards minority groups, including those with mental health issues (Lu et al., 2020). Moreover, the presence of ethnocultural empathy can serve as a protective factor against the negative impacts of microaggressions. Individuals who possess a strong sense of ethnocultural empathy are more likely to engage in supportive behaviours and less likely to perpetuate harmful stereotypes about mental illness (Rasoal et al., 2011).

As a result of the regression analysis, female gender, higher economic status and religious beliefs were found to be significant predictors of microaggression towards mental illnesses. Microaggressions, which are subtle, often unintentional discriminatory remarks or behaviours, can vary significantly based on the gender of both the perpetrator and the target, leading to distinct psychological outcomes for individuals affected by mental illness. A review of the literature has shown that endorsement of microaggressions against individuals with mental health issues is often influenced by broader societal attitudes, including political views and socioeconomic factors. For example, individuals with right-wing political beliefs and those from socioeconomically disadvantaged backgrounds are more likely to endorse microaggressions against individuals with mental health issues (Barber et al., 2019). This correlation suggests that microaggressions are not merely individual acts of prejudice, but are embedded in larger societal structures that perpetuate stigma and discrimination against mental illness (O'Connor et al., 2018).

As a result, negative attitudes and microaggressions toward mental illness are a significant barrier to recovery and social integration. The internalization of these negative attitudes can lead to reluctance to seek help or disclose their mental health condition, further isolating them from supportive networks (Follmer & Jones, 2017). The impact of microaggressions is particularly pronounced in settings where individuals are expected to receive care, such as mental health treatment programs, and may encounter microaggressions from both peers and professionals in these settings (Deres et al., 2020). Such experiences can undermine the therapeutic alliance and hinder effective treatment outcomes as individuals may feel judged or misunderstood by those who are supposed to provide support. Negative outcomes reported related to microaggression experiences include isolation, negative emotions, and poor treatment compliance (Gonzales et al., 2015). Additionally, the loss of social support reported in one study and the frequent occurrence of microaggressions in close relationships suggest that these experiences may contribute to the internalization of stigmatizing attitudes toward mental illness (Barber et al., 2019). The role of cultural context in shaping the experience of microaggressions related to mental illness cannot be ignored. For example, in collectivist cultures, the stigma associated with mental illness may be particularly pronounced, as individuals may feel greater shame or responsibility toward their families and communities (Ma et al., 2022). This cultural dimension can complicate the recovery journey of individuals with mental illness, as they may face additional pressures to conform to societal expectations while grappling with their own mental health issues (Park et al., 2023). Understanding these cultural nuances is important for developing effective interventions that address the unique needs of diverse populations (Zoubaa et al., 2020).

5. Conclusion

New research on microaggressions is important in determining the breadth and depth of the problem. When the existing literature is examined, new research on microaggressions mostly addresses issues such as race and gender, while very few studies have focused on individuals with mental health disorders. It is thought that some types of microaggressions are better represented in the literature than others. In this context, there is a need for more in-depth studies that examine microaggressions against mental illnesses from both the perspective of the victim and the perpetrator.

Understanding the social and cultural contexts that shape experiences of microaggressions for mental illness is essential to developing effective interventions that address the unique needs of individuals with mental illness. By promoting awareness and empathy, society can work to reduce the prevalence of microaggressions and create a more inclusive environment for all

individuals, regardless of their mental health status.

Given the fluid, ambiguous nature of microaggressions, supporting people with mental health issues to cope with these slights, put-downs, and insults may be critical to reducing the impact of microaggressions. Focusing on strategies that increase self-esteem in individuals with mental illness may reduce the negative impact of microaggressions. Furthermore, awareness and prevention programs for those who perpetrate microaggressions may reduce negative attitudes toward mental illness. Educational interventions that increase awareness of the impact of microaggressions and promote empathy toward individuals with mental illness may play a vital role in reducing these harmful behaviours.

5.1. Limitations of the Study

The current study fills an important gap in the literature by examining microaggression towards individuals with mental disorders in Turkey in terms of some sociodemographic characteristics, religious belief and ethnocultural empathy. However, the study has some limitations that need to be considered in future research. The generalizability of the results of this cross-sectional study is a limitation. There is a need for longitudinal studies to identify the long-term effects of microaggression towards mental illness on people with severe mental illness. Sample size of study is another limitation of the study. Qualitative study will help to understanding comprehensively the microaggression process both victims and perpetrators. Additionally, the results of the study based on self-report are known to have social desirability.

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