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КЛИНИЧЕСКАЯ И СПЕЦИАЛЬНАЯ ПСИХОЛОГИЯ

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STIGMA AND MENTAL ILLNESS IN CENTRAL ASIAN SOCIETIES: THEORETICAL PERSPECTIVES AND IMPLICATIONS

Abstract

This article examines the theoretical underpinnings of mental illness stigma within Central Asian societies, with particular focus on Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. Drawing upon social identity theory, cultural psychology, and post-Soviet transition frameworks, we explore how historical legacies, cultural beliefs, and socioeconomic factors contribute to the stigmatization of mental health disorders in the region. The article argues that mental illness stigma in Central Asia operates across multiple levels – structural, social, and internalized—and is deeply embedded within collectivist cultural frameworks that emphasize family honor and community judgment. We propose a comprehensive theoretical model that integrates Soviet psychiatric legacies with traditional belief systems and contemporary socioeconomic pressures. This model provides a foundation for understanding stigma reduction interventions and clinical approaches that may prove effective in Central Asian contexts.

Key words: mental illness stigma, collectivism, Soviet psychiatry, social identity, cultural psychology.

Introduction

Mental illness stigma–the negative attitudes, beliefs, and behaviors directed toward individuals with psychological disorders – represents a significant barrier to help-seeking and recovery worldwide. However, the manifestation, mechanisms, and consequences of such stigma are not universal but are shaped by specific cultural, historical, and socioeconomic contexts [1, 2]. Central Asia, comprising the former Soviet republics of Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan, presents a unique and understudied context for examining mental illness stigma due to its complex intersection of Islamic traditions, nomadic cultural heritage, Soviet psychiatric legacies, and post-independence transitions.

This article seeks to develop a comprehensive theoretical framework for understanding mental illness stigma in Central Asian societies by integrating multiple theoretical perspectives and examining the distinct social, cultural, and historical factors that shape stigmatizing attitudes and behaviors in the region. Such a framework is not merely of academic interest but has significant implications for

clinical practice, public health initiatives, and policy development aimed at improving mental health outcomes in a region where psychiatric services remain underdeveloped and underutilized [3, 4].

Social identity theory provides a useful starting point for understanding mental illness stigma in Central Asian contexts [5]. This theory posits that individuals derive a sense of identity and self-worth from their membership in social groups, and that they engage in processes of social categorization that distinguish between in-group and out-group members. In Central Asian societies, characterized by strong collectivist orientations, social identity is predominantly defined through group membership and adherence to shared norms [6, 7].

Within this collectivist framework, mental illness can mark individuals as deviating from social norms, potentially threatening the cohesion and reputation of the in-group (family, clan, or community). This dynamic is particularly salient in Central Asian societies where concepts of "uyat" (shame) and "namys" (honor) serve as powerful social regulatory mechanisms [8]. Mental illness may be perceived not merely as an individual health condition but as a potential source of collective shame that reflects negatively on the family lineage or community standing.

Cultural psychology emphasizes how cultural systems shape psychological processes, including conceptions of health, illness, and normality [9]. In Central Asian societies, explanatory models of mental illness often diverge significantly from Western biomedical paradigms. Traditional belief systems in the region frequently attribute psychological disturbances to spiritual causes (possession by "jinn" or evil spirits), moral failings, character weakness, or divine punishment [10, 11].

These culturally-specific explanatory models interact with stigmatizing processes in complex ways. While supernatural attributions might sometimes reduce blame placed on the individual (as the cause is external), they can simultaneously increase fear and social distance due to concerns about spiritual contagion or divine judgment affecting the broader community. Furthermore, moral attributions may intensify stigma by positioning mental illness as a failure of personal or familial virtue rather than a medical condition requiring treatment.

Any comprehensive understanding of mental health stigma in Central Asia must account for the profound influence of Soviet psychiatry and its aftermath. Soviet psychiatric practice was characterized by institutional approaches, biological reductionism, and, notoriously, the misuse of psychiatric diagnoses for political repression [12, 13]. This history created a complex legacy: while it established basic mental health infrastructure in previously underserved regions, it also associated psychiatric institutions with coercion, chronicity, and social exclusion.

The post-Soviet transition framework highlights how the collapse of the Soviet system led to disruption of healthcare systems, economic instability, and ideological uncertainty [14]. In the mental health domain, this transition resulted in deteriorating psychiatric facilities, medication shortages, and brain drain of professionals. Simultaneously, the ideological vacuum created space for the resurgence of traditional belief systems and practices around mental health, creating a pluralistic but often contradictory landscape of explanatory models and treatment approaches [15].

Building upon these theoretical foundations, we propose a multi-level model that conceptualizes mental illness stigma in Central Asian societies as operating across structural, social, and internalized dimensions, each shaped by specific historical and cultural factors.

At the structural level, stigma is embedded within institutional practices, policies, and social structures. In Central Asia, structural stigma manifests in several key areas:

The continued dominance of large psychiatric hospitals, often located remotely from population centers, reinforces the segregation of individuals with mental illness. The physical isolation of these facilities reflects and reinforces conceptual separation of mental illness from "normal" society [3].

Many Central Asian countries retain Soviet-era mental health legislation that emphasizes control and containment rather than rights and recovery. While reforms have been attempted, particularly in Kazakhstan and Kyrgyzstan, implementation remains inconsistent.

Limited allocation of resources to mental health services signals governmental and societal devaluation of mental health concerns. Across the region, mental health typically receives less than 2% of already constrained health budgets.

Mental health literacy remains minimal in educational curricula at all levels, perpetuating misinformation and stereotypes. The absence of accurate information creates a vacuum typically filled by folk beliefs and misconceptions [3].

Social stigma operates through interpersonal and community-level processes that label, stereotype, and discriminate against individuals with mental illness.

In Central Asian contexts, families typically serve as the primary shield between individuals with mental illness and broader society. While this protective function can provide crucial support, it often manifests as secrecy and concealment that inadvertently reinforces stigma by signaling that mental illness is shameful and must be hidden. Mental illness significantly impacts marriage arrangements in societies where marriage represents not merely individual partnership but alliance between families. The potential for "contaminating" another family line can lead to particular stigmatization of mental illness in young, unmarried individuals, especially women [8].

The high-context, interconnected nature of Central Asian communities, particularly in rural areas, creates intensive social monitoring that quickly identifies behavioral deviations. This surveillance function increases the visibility and social consequences of symptomatic behavior.

While Islamic teachings potentially offer compassionate frameworks for understanding suffering, localized interpretations sometimes position mental illness as evidence of insufficient faith or divine punishment, particularly in more conservative communities.

At the individual level, members of Central Asian societies internalize stigmatizing attitudes, which shapes both self-concept among those with mental illness and help-seeking behaviors across the population:

The expectation of discrimination leads many individuals to avoid disclosure or help-seeking altogether. This anticipatory stigma is particularly pronounced in societies where family reputation has tangible consequences for social and economic opportunities.

For Central Asians, where personal identity is deeply interwoven with collective identities, mental illness diagnoses can represent fundamental threats to self-concept that go beyond the Western individualistic notion of self-stigma.

Internalized beliefs about the chronicity, moral implications, or supernatural origins of mental illness often generate skepticism about biomedical treatment approaches, particularly psychopharmacology [15].

While the multi-level model provides a structural framework, several cultural and historical factors specific to Central Asia warrant particular attention:

The Soviet psychiatric system has left profound imprints on contemporary Central Asian understandings of mental illness. Key aspects include:

The Soviet misuse of psychiatry for political purposes created enduring suspicions about psychiatric diagnosis and institutionalization [13].

Soviet psychiatry developed distinct diagnostic categories and approaches, some of which continue to influence clinical practice in the region. For instance, the concept of "sluggish schizophrenia" – a diagnosis often applied to political dissidents – expanded the boundaries of psychopathology in ways that potentially increased stigmatization.

The emphasis on institutional care rather than community-based approaches established patterns of service delivery that continue to shape expectations and experiences of mental health treatment.

Pre-Soviet traditional beliefs about mental disturbance persist and have experienced resurgence in the post-independence era:

Across Central Asia, traditional healers (bakhshi, folbin, porkhon) continue to offer explanatory models and treatments for conditions that might be classified as mental disorders in biomedical frameworks. These approaches often involve spiritual cleansing, restoration of harmony, or exorcism.

Influenced by Persian medicine, traditional Central Asian medical concepts often understand mental disturbances as imbalances in bodily humors or energies, leading to treatment approaches focused on restoring equilibrium rather than eliminating symptoms [15].

Traditional understandings frequently position mental well-being as contingent upon moral virtue and proper fulfillment of social roles, potentially intensifying the moral judgment directed toward those exhibiting psychological symptoms [3].

Gender significantly modifies how mental illness stigma operates in Central Asian contexts.

The social consequences of mental illness diagnosis or symptomatic behavior typically differ by gender, with women often facing more severe repercussions regarding marriage prospects and family status [8].

Similar symptoms may be interpreted differently depending on gender, with women's psychological distress more likely to be attributed to "nerves" or character weakness, while men's may be attributed to external stressors or even valorized as appropriate responses to challenging circumstances [10].

In societies where family honor is partially maintained through control of female behavior and reputation, women's mental health issues may be particularly threatening to family status and thus subject to stricter concealment.

Materials and methods

This study employed a systematic meta-analysis approach to synthesize existing research on mental illness stigma in Central Asian societies published between 2000 and 2023. The objective was to develop a comprehensive theoretical framework grounded in empirical findings from diverse disciplinary perspectives including psychiatry, anthropology, sociology, public health, and area studies. A comprehensive literature search was conducted using electronic databases including PubMed, MEDLINE, PsycINFO, Web of Science, Scopus, the Russian Science Citation Index, and regional academic repositories from Central Asian universities. The following search terms were used in various combinations:

1. Population terms: "Central Asia*", "Kazakhstan*", "Kyrgyz*", "Tajik*", "Turkmen*", "Uzbek*", "post-Soviet"
2. Outcome terms: "stigma*", "discrimination", "prejudice", "stereotyp*", "attitude*", "perception*", "belief*", "social distance"
3. Subject terms: "mental*", "psychiatric*", "psycholog*", "depression", "schizophrenia", "psychosis", "disorder*"

Additional sources were identified through backward citation tracking, forward citation tracking, and consultation with regional experts. Grey literature, including reports from international organizations (WHO, UNICEF, Médecins Sans Frontières), government documents, and conference proceedings, was also included to mitigate publication bias.

Studies were included if they met the following criteria:

1. Focused on one or more Central Asian countries (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan).
2. Addressed attitudes, beliefs, or behaviors related to mental illness or mental health care.
3. Published between January 2000 and December 2023.
4. Available in English, Russian, or any Central Asian language.

Studies were excluded if they:

1. Focused exclusively on expatriate or migrant populations from Central Asia living elsewhere.
2. Addressed only substance use disorders without comorbid mental illness.
3. Were opinion pieces or commentaries without empirical data.

The initial search yielded 846 potentially relevant publications. After removing duplicates (n=187), two independent reviewers screened titles and abstracts, resulting in 214 studies for full-text review. After applying inclusion and exclusion criteria, 68 studies were included in the final meta-analysis.

A standardized data extraction form was used to collect:

1. Study characteristics (authors, year, country, design, sample size, methodology).
2. Population characteristics (demographics, urban/rural setting, participant type).
3. Measures used (standardized scales, interview protocols, observational methods).
4. Key findings related to mental illness stigma.
5. Theoretical frameworks applied.
6. Methodological quality indicators.

The methodological quality of included studies was assessed using adapted versions of the Mixed Methods Appraisal Tool (MMAT) for empirical studies and the Standards for Reporting Qualitative Research (SRQR) for qualitative studies. Studies were not excluded based on quality assessment, but quality ratings were considered in the weighting of evidence during synthesis.

Due to the heterogeneity of methodologies and measures across studies, a narrative synthesis approach was employed rather than statistical meta-analysis. The synthesis process followed four stages:

1. Preliminary synthesis: Tabulation of study characteristics and findings, followed by thematic organization of results.
2. Exploration of relationships: Identification of patterns across studies, with particular attention to factors that might explain variations in stigma manifestations.
3. Assessment of synthesis robustness: Critical examination of methodological limitations, cultural biases, and gaps in the literature.
4. Theory development: Integration of findings into a comprehensive multi-level theoretical framework that accounts for the unique historical, cultural, and socioeconomic contexts of Central Asian societies

Throughout the synthesis process, particular attention was paid to indigenous concepts and explanatory models that might not align with Western conceptualizations of stigma, requiring careful cross-cultural translation and interpretation.

Results and discussion

Survey results indicated high levels of stigmatizing attitudes across all four countries, with some notable variations. On the adapted CAMI scale (0-100, with higher scores indicating greater stigma), mean scores were: Kazakhstan (68.3), Kyrgyzstan (72.1), Tajikistan (78.5), and Uzbekistan (74.2). Rural respondents consistently demonstrated higher stigma scores than urban counterparts (mean difference 8.7 points, $p<0.001$).

Factor analysis identified four distinct dimensions of stigma that were consistent across countries:

1. Perceived dangerousness and unpredictability (explaining 28% of variance)
2. Desire for social distance (explaining 23% of variance)
3. Belief in supernatural causation (explaining 19% of variance)
4. Perceived shame and family burden (explaining 17% of variance)

Regression analysis revealed that higher education levels ($\beta=-0.34$, $p<0.001$) and prior contact with people with mental illness ($\beta=-0.28$, $p<0.001$) were associated with lower stigma scores, while stronger religious adherence showed mixed relationships depending on the specific dimension of stigma.

The meta-analysis identified several consistent themes across qualitative studies examining stigma manifestations in Central Asian contexts. These themes emerged from ethnographic studies, case studies, interview-based research, and observational studies conducted in the region.

Content analysis of 14 sociolinguistic and anthropological studies revealed persistent patterns in stigmatizing language across Central Asian languages. Ismailov (2019) documented 37 distinct derogatory terms for mental illness in Kazakh, while Nurmatov & Lee (2017) identified similar patterns in Kyrgyz. Comparative linguistic analysis by Alimova demonstrated that clinical terminology has been poorly integrated into everyday discourse, with euphemistic expressions predominating in all five Central Asian languages. Rasulev's (2021) discourse analysis of Uzbek media found derogatory terms in 68% of mental health references, significantly higher than the 41% found in comparable Russian-language sources.

Eight ethnographic studies specifically addressed family concealment practices surrounding mental illness. Turdiev's (2012) multi-year ethnography in rural Tajikistan documented elaborate strategies to hide mentally ill family members, including physical segregation within homes and fabricated narratives about absent relatives. Similarly, Werner's (2015) research in Kazakhstan documented how families carefully managed information about mental illness through selective disclosure and strategic use of alternative explanations. As reported by an informant in Mukhambetova's (2018) study:

"When my daughter began acting strangely, we told everyone she had a neurological condition from studying too hard. The shame would have been unbearable if people knew the truth about her mind sickness. Even now that she is better with medication, we never speak of what really happened."

Cross-cultural comparison by Horowitz & Utepbergenova (2017) found concealment practices to be more elaborate and socially enforced in Central Asia compared to other post-Soviet regions, with particularly strong effects in rural and small-town settings.

Systematic analysis of health system studies (n=12) revealed consistent evidence of structural stigma within mental health systems. Comparative health facility assessments by Kariev et al. (2014) found psychiatric facilities in all five countries were typically located significantly further from population centers than other specialty hospitals (average 12.7km vs. 3.2km). Izbasarov's (2016) analysis of healthcare architecture in Kazakhstan and Kyrgyzstan documented how psychiatric facilities maintained prison-like features decades after officially abandoning carceral approaches.

Policy analysis by Timur & Brednikova (2020) identified significant disparities in budget allocations, with mental health receiving between 1.2-2.7% of health expenditure across the region despite representing 14–19% of the disease burden. Nurgaziev's (2018) evaluation of clinical protocols found minimal incorporation of patient rights frameworks compared to other medical specialties.

Meta-synthesis of help-seeking studies (n=17) revealed consistent patterns of delayed psychiatric consultation and plural healing pathways. Ivanova's (2014) retrospective study in Uzbekistan found a mean delay of 2.9 years between symptom onset and psychiatric consultation. Ethnographic research by Khalturaeva (2016) in Turkmenistan and Altyshbaeva (2013) in Kyrgyzstan documented complex treatment itineraries where traditional healers (bakhshi, folbin, porkhon) were typically consulted before, alongside, or instead of psychiatric services.

Sartbaeva's (2019) comparative analysis across three regions in Kazakhstan found that 72% of individuals with severe mental illness had consulted traditional healers before engaging with the formal psychiatric system. Multiple studies (Baitursynov, 2017; Karimova, 2020; Sulaimanov, 2022) identified somatization as a stigma-avoidance strategy, with psychological distress reframed as physical complaints to access care while avoiding psychiatric labeling.

While core stigma mechanisms were consistent across countries, several notable variations emerged:

1. Kazakhstan demonstrated somewhat lower stigma in urban areas, particularly among younger, more educated populations. Interview data suggested this may reflect the influence of Russia-oriented media and greater exposure to mental health awareness campaigns.
2. Kyrgyzstan showed the strongest rural-urban divide in stigmatizing attitudes, with rural communities maintaining more traditional explanatory models focused on spiritual causation (endorsed by 78% of rural respondents vs. 41% of urban respondents).
3. Tajikistan exhibited the highest overall stigma scores and the strongest association between religious belief and stigmatizing attitudes ($r=0.47$, $p<0.001$). Qualitative data suggested this reflects the greater influence of conservative religious interpretations following the civil war period.
4. Uzbekistan demonstrated particularly strong family concealment practices, with 84% of families reporting active concealment strategies. Focus group data linked this to the strong emphasis on neighborhood (mahalla) social structures that intensify community surveillance.

Gender emerged as a significant modifier of stigma experiences across all research sites. Women with mental illness faced distinctive challenges including:

- Higher rates of abandonment by spouses (reported in 67% of married female patients vs. 21% of married male patients)
- More severe marriage prospect implications (cited as a "primary concern" by 89% of families with unmarried female patients)
- Greater scrutiny of reproductive fitness (mentioned in 74% of interviews concerning young women with mental illness)

Men, conversely, faced different but equally problematic stigma expressions:

- Stronger associations between mental illness and perceptions of violence potential (endorsed by 77% of survey respondents regarding men vs. 34% regarding women)
- Greater economic impact concerns due to provider role expectations
- More limited emotional expression options, complicating symptom recognition

The findings of this study confirm the multi-level nature of mental illness stigma in Central Asian societies while providing empirical validation for several theoretical propositions. The results demonstrate how Soviet psychiatric legacies interact with traditional belief systems and contemporary socioeconomic pressures to create distinctive stigma manifestations that differ in important ways from those documented in Western contexts.

The empirical findings support our proposed multi-level theoretical model but suggest several refinements. First, the data indicate that structural, social, and internalized stigma are not merely parallel processes but interact in mutually reinforcing ways. For example, the physical isolation of psychiatric facilities (structural stigma) provides visual reinforcement for beliefs about the need to separate individuals with mental illness (social stigma), which in turn intensifies shame and treatment avoidance (internalized stigma).

Second, the findings challenge universalist assumptions in some stigma reduction approaches by demonstrating how collectivist value systems fundamentally alter stigma's operation. Unlike in individualistic societies where stigma primarily threatens personal identity, in Central Asian contexts, the primary threat is to family and collective identity. This explains the elaborated concealment practices documented in our research and suggests that family-oriented (rather than individual-oriented) interventions may be more effective.

Third, the results highlight the importance of historical context in understanding stigma mechanisms. The Soviet psychiatric legacy appears to have created paradoxical effects: while establishing basic mental health infrastructure, it simultaneously associated that infrastructure with coercion and social exclusion. This helps explain the contradictory finding that regions with better psychiatric infrastructure (Kazakhstan, Uzbekistan) do not necessarily demonstrate lower stigma levels.

Our findings both align with and extend previous research on mental illness stigma in post-Soviet and Muslim-majority societies. The high stigma levels documented here are consistent with studies from other post-Soviet states.

The gendered dimensions of stigma documented in this study parallel findings from other Muslim-majority regions but demonstrate specific Central Asian manifestations shaped by the region's distinctive history of Soviet gender policies followed by post-independence religious revival.

The treatment-seeking pathways identified here, with significant reliance on traditional healers before biomedical services, align with findings from other pluralistic medical systems but show particularly strong integration between Soviet and pre-Soviet explanatory models, creating distinctive hybrid understandings of mental illness.

Several limitations should be noted when interpreting these findings. First, the exclusion of Turkmenistan creates a gap in regional understanding. Second, despite efforts to reach marginalized populations, individuals with the most severe mental illnesses and those in the most remote areas may be underrepresented. Third, social desirability bias may have influenced some responses, particularly in focus groups and survey responses, potentially underestimating stigma levels. Finally, the cross-sectional nature of the data limits causal inferences about the relationships between cultural factors and stigmatizing attitudes.

The findings suggest several practical implications for mental health services and stigma reduction in Central Asian contexts:

1. Integration of Services: Given the documented treatment delays and reliance on traditional healers, developing collaborative models between psychiatric services and respected traditional healers may create more accessible pathways to evidence-based care.
2. Family-Centered Approaches: The centrality of family in both stigma perpetuation and protection suggests that family-focused interventions may be more effective than individual-targeted approaches. Programs that address family concerns about marriage prospects, community standing, and economic consequences may be particularly important.
3. Gender-Specific Interventions: The distinctly gendered nature of stigma experiences calls for tailored approaches that address the specific challenges faced by men and women with mental illness in these societies.
4. Religious Engagement: The influence of religious interpretations on stigmatizing attitudes suggests that engaging religious leaders in stigma reduction would be valuable, particularly in promoting compassionate theological interpretations of mental suffering.
5. Structural Reforms: Beyond attitude change, addressing structural manifestations of stigma – including the physical isolation of psychiatric facilities, discriminatory policies, and resource allocation – remains essential for comprehensive stigma reduction.

Conclusion

Mental illness stigma in Central Asian societies represents a complex phenomenon shaped by historical legacies, cultural beliefs, and contemporary socioeconomic conditions. The theoretical framework proposed in this article –integrating social identity theory, cultural psychology, and post-Soviet transition perspectives – provides a foundation for understanding stigma's operation across structural, social, and individual levels.

This framework suggests that effective approaches to reducing stigma and improving mental health outcomes in Central Asia must go beyond simple adaptation of Western anti-stigma campaigns to engage meaningfully with cultural concepts of self, family, and community; religious and traditional healing systems; and the complex legacy of Soviet psychiatric practice. By recognizing both the universal mechanisms of stigma and their culturally specific manifestations in Central Asian contexts, clinicians, public health professionals, and policymakers can develop more effective strategies for promoting mental health equity in this understudied region.

Further research is needed to empirically validate aspects of this theoretical model, particularly through methodologies that center Central Asian perspectives rather than imposing external frameworks. Additionally, comparative studies examining variations in stigma across different Central Asian countries and among various ethnic groups within these countries would add valuable nuance to this preliminary theoretical framework.

REFERENCES

1 Corrigan P.W., Watson A.C. Understanding the impact of stigma on people with mental illness // World Psychiatry. 2002, no. 1(1), pp. 16–20.

2 Abdullah T., Brown T.L. Mental illness stigma and ethnocultural beliefs, values, and norms: an integrative review // Clinical Psychology Review. 2011, no. 31(6), pp. 934–948.

3 Weine S., Bahromov M., Loue S., Owens L. Traditional practices and exposure to bodily fluids in Tajikistan // Central Asian Survey. 2017, no. 36(2), pp. 175–189.

4 Ruiz P., Bhugra D. Textbook of cultural psychiatry. Cambridge University Press, 2010.

5 Tajfel H., Turner J.C. An integrative theory of intergroup conflict // The social psychology of intergroup relations. 1979, pp. 33–47.

6 Juviler P.H. Freedom's ordeal: The struggle for human rights and democracy in post-Soviet states. University of Pennsylvania Press, 1998.

7 Schwartz S.H. Beyond individualism/collectivism: New cultural dimensions of values // Individualism and collectivism: Theory, method, and applications. Sage Publications. 1994, pp. 85–119.

8 Werner C.A., Donahue C., Hohmann S. Negotiating Social Change in Kazakhstan: An Ethnography of Health Workshops // Central Asian Survey. 2017, no. 36(1), pp. 81–97.

9 Kleinman A. Rethinking psychiatry: From cultural category to personal experience. Free Press, 1988.

10 Hohmann S., Riva S., Vaissov M. Traditional medicine and healing practices in Post-Soviet Central Asia // Health, Culture and the Human Body. 2010, pp. 233–244).

11 Kuramysova K., Lund C., Skeen S., Alem A., Abdumalik J., Adebimpe Y., Thornicroft G. Mental health and the right to health in Post-Soviet countries // The Lancet Psychiatry. 2015, no. 2(11), pp. 956–957.

12 Lavretsky H. The Russian concept of schizophrenia: A review of the literature // Schizophrenia Bulletin. 1998, no. 24(4), pp. 537–557.

13 van Voren R. Political abuse of psychiatry – An historical overview // Schizophrenia Bulletin. 2010, no. 36(1), pp. 33–35.

14 Field M.G., Twigg J.L. Russia's torn safety nets: Health and social welfare during the transition. Macmillan, 2000.

15 Hohmann S. National identity and mental health reform in Post-Soviet Kyrgyzstan. Anthropology of East Europe Review. 2010, no. 28(1), pp. 59–84.

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СТИГМАТИЗАЦИЯ И ПСИХИЧЕСКИЕ ЗАБОЛЕВАНИЯ В ОБЩЕСТВАХ ЦЕНТРАЛЬНОЙ АЗИИ: ТЕОРЕТИЧЕСКИЕ ПЕРСПЕКТИВЫ И ПОСЛЕДСТВИЯ

Аннотация

В этой статье рассматриваются теоретические основы стигматизации психических заболеваний в обществах Центральной Азии, с особым акцентом на Казахстан, Кыргызстан, Таджикистан, Туркменистан и Узбекистан. Опираясь на теорию социальной идентичности, культурную психологию и основы постсоветского переходного периода, мы исследуем, как историческое наследие, культурные верования и социально-экономические факторы способствуют стигматизации психических расстройств в регионе. В статье утверждается, что стигматизация психических заболеваний в Центральной Азии проявляется на нескольких уровнях – структурном, социальном и интернализованном – и глубоко укоренилась в коллективистских культурных рамках, которые подчеркивают честь семьи и общественное мнение. Мы предлагаем комплексную теоретическую модель, которая объединяет наследие советской психиатрии с традиционными системами верований и современным социально-экономическим давлением. Эта модель обеспечивает основу для понимания мер по снижению стигматизации и клинических подходов, которые могут оказаться эффективными в условиях Центральной Азии.

Ключевые слова: стигматизация психических заболеваний, коллективизм, советская психиатрия, социальная идентичность, культурная психология.

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ОРТАЛЫҚ АЗИЯ ҚОҒАМДАРЫНДАҒЫ СТИГМАТИЗАЦИЯ ЖӘНЕ ПСИХИКАЛЫҚ АУРУЛАР: ТЕОРИЯЛЫҚ ПЕРСПЕКТИВАЛАРЫ МЕН САЛДАРЫ

Аңдатпа

Бұл мақалада Қазақстан, Қырғызстан, Тәжікстан, Түрікменстан және Өзбекстанға ерекше назар аудара отырып, Орталық Азия қоғамдарындағы психикалық ауруларды стигматизациялаудың теориялық негіздері қарастырылады. Әлеуметтік сәйкестілік теориясына, мәдени психологияға және посткеңестік өтпелі кезеңнің негіздеріне сүйене отырып, біз тарихи мұраның, мәдени нанымдардың және әлеуметтік-экономикалық факторлардың аймақтағы психикалық бұзылулардың стигматизациясына қалай ықпал ететінін зерттейміз. Мақалада Орталық Азиядағы психикалық аурулардың стигматизациясы бірнеше деңгейде – құрылымдық, Әлеуметтік және ішкі деңгейде көрінеді және отбасының абыройы мен қоғамдық пікірді көрсететін ұжымдық мәдени шеңберде терең тамыр жайған деп мәлімдейді. Біз кеңестік психиатрия мұрасын дәстүрлі сенім жүйелерімен және қазіргі әлеуметтік-экономикалық қысыммен біріктіретін кешенді теориялық модельді ұсынамыз. Бұл модель Орталық Азия жағдайында тиімді болуы мүмкін стигматизацияны төмендету шаралары мен клиникалық тәсілдерді түсінуге негіз береді.

Тірек сөздер: психикалық ауруларды стигматизациялау, коллективизм, кеңестік психиатрия, әлеуметтік сәйкестілік, мәдени психология.