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Original Research

English language learning in patients suffering from mental disorders: A different concept of self-stigma

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Abstract

Background: There are increasing challenges related to mental health in the public health system, and almost 80% of mental illnesses are reported in low- and middle-income countries. The stigma associated with mental illness leads to reduced access to health services, inadequate treatment, and poor outcomes. This paper, drawing on Norton[1] conceptualization of language investment, investigates the effect of English language learning on self-stigma among patients suffering from mental disorders.

Methods: An experimental design with a pre-post test format and a six-month follow-up with English language instruction and a control group was used for this study. A total of 52 adults with mental illness diagnoses from a center for patients suffering from mental disorders in Isfahan, Iran, participated in this study. Data were collected using an English language proficiency test and the Self-Stigma of Mental Illness Scale (SSMIS), a self-report questionnaire to assess the internalization of stigmatic views.

Results: The analysis indicated that the experimental group showed significant improvements in being empowered with higher levels of English language proficiency and stigma reduction ($P < 0.01$). The findings of this study provide theoretical support for Norton's model of investment and demonstrate its applicability among people with mental problems. Furthermore, the study provides evidence that it is feasible to implement successful English language teaching among patients with mental illness, which has received insufficient attention in academic studies.

Conclusion: Policymakers, psychiatrists, doctors, and people dealing with mental diseases can use English language instruction to reduce stigma and promote a non-stigmatizing attitude among people with mental illnesses. The current study contributes to our understanding of English language teaching in the medical field. Results of the study support the use of second-language teaching to reduce stigma among people suffering from mental illnesses.

Introduction

This paper, drawing on Norton's[1] conceptualization of language investment, investigates the effect of English language learning on self-stigma using a Self-Stigma of Mental Illness Scale (SSMIS)[2] among patients suffering from mental disorders. Mental problems affect the mental health of one out of three people at some point in their everyday lives.[3] Common mental illnesses include depression, anxiety, bipolar disorder, schizophrenia, dementia, substance abuse, attention deficit hyperactivity disorder, and developmental disorders such as autism. Mental problems affect people of all classes, but the poor are disproportionately affected. This is particularly evident in the 153 low and middle-income countries, which make up 85 percent of the world's population and have more than 80% of the mental health disorder population.[4,5] In low and middle-income nations, depression will be the third and second leading causes of illness burden, respectively, by 2030.[5] Several factors explain the high mental health burden in low- and middle-income countries, including poverty, unemployment, low educational status, rapid urbanization, lifestyle changes, and racial discrimination.[4-6]

Consequently, being diagnosed with a mental health problem results in stigma for the patient. Stigma is a combination of negative beliefs and attitudes and a form of discrimination that results in individuals with mental problems being incorrectly labeled.[7] Several destructive consequences result from this form of stigma, including a decrease in seeking treatment.[8]

Nowadays, mental illness is so stigmatized that most institutions have tried to find a solution.[9] Patients, their families, the health care system, and society are all negatively affected by mental illness stigma in different

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ways.[10,11] Stigma can be seen in public and as a form of self-stigma. Public stigma includes cognitive, affective, and behavioral reactions of those stigmatizing; self-stigma includes the belief that one is being stigmatized, and internalizing the negative feelings and beliefs associated with the stigmatized condition. Stigma by association involves social and psychological responses to people associated with a stigmatized person (e.g., family and friends).[12] More than 40% of schizophrenia patients experience high levels of stigma according to recent studies on self-stigma,[13] and some even regard stigma as an additional disease.[14] Despite controlling for symptom levels, adverse effects of stigma on self-esteem,[15,16] quality of life, empowerment, mental health care,[17,18] and suicidality have been reported.[19] Stigma negatively impacts employment, income, and healthcare costs.[20] Therefore, defeating prejudice and promoting diversity requires understanding stigmatization and its causes.[21] Goffman's[22] work has introduced stigma in three dimensions: (1) Stereotypes are views held about a person based on his or her membership in a group (e.g., beliefs about dangerousness, incompetence, prediction failure, and responsibility), (2) Prejudices are views about a person based on his or her group membership (e.g., fear, empathy), and (3) Discrimination is a behavioral reaction according to Corrigan and Penn and Fiske's studies.[23,24] In a recent qualitative study, Mestdagh and Hansen[25] reported that mental health professionals are among the basic sources of stigmatization among people with schizophrenia.

Several researchers consider the second language acquisition (SLA) classroom as a place where social, cultural, and political challenges of learning a second language shape second-language (L2) learners' identities,[26-31] holding that these socially structured/restructured identities are numerous, varied, and clashing.[32-35] As Ricento[36] points out, sociocultural approaches to identity do not consider identity as a fixed and unchangeable property in the mind of each learner. Instead, they focus on how individuals interact with the surrounding world and possess experiences within sociocultural frameworks in a dialectical way. Norton's[30,33] study emphasizes that these connections are shaped "across time and space" (p. 5), and finds "similarities across conceptions of identity and the collapsing of boundaries between the 'society' and 'culture'. Norton[30] mentions that identity is complex, inconsistent, and different and is constructed through relations by language.[28] Since language is the most effective means of communication and identity (de)construction in the classroom, Barnawi[37] believes that language and identity should be understood as interwoven concepts, explaining the vital role of students' participation in a particular group. In this way, language helps L2 learners to acquire participation, validity, and membership in L2-mediated academic and non-academic discourse groups as a linguistically mediating instrument.[28,38-41] As a result, the current study focuses on the effect of learning the English language on stigma among people with mental illnesses.

Materials and Methods

Participants of this study were 52 adults with mental illness from a center for patients suffering from mental disorders in Isfahan, Iran. Participants had to have a mental illness according to the ICD-10,[42] take psychiatric medications, be inpatients or outpatients under any form of mental care, and be between 25 and 55 years of age. They also had to take the English language proficiency test and complete a self-stigma questionnaire based on their psychiatrist's assessment. The criteria for exclusion in this study were (a) severe illness, (b) brain disorder, (c) incapability to complete the questionnaire, or (d) not agreeing to participate. Those patients meeting the study inclusion criteria were contacted by their treating psychiatrists. Once the patient agreed to participate, informed consent was obtained. Patients also received an overview of the study's goals. According to established translation protocols, the questionnaire was translated from English to Persian and back-translated from Persian to English.[43] Disparities between the original and translated versions were addressed and corrected in the back-translation. The ethical aspects of the program have been approved by a regional hospital responsible for patient welfare.

A language proficiency pre-test was given to identify whether the participants were at a comparable level at the beginning of the study to select the beginner participants to ensure the homogeneity of learners in terms of English proficiency. The test content focused on listening, speaking, reading, writing, vocabulary, and grammar. The test followed topics covered in class, and the language was defined in the syllabus at this level and did not include new items. The questions were descriptive, therefore, participants did not need to use their world knowledge to answer the questions. We used the Self-Stigma of Mental Illness Scale (SSMIS) to measure the pre-test stigma level. The SSMIS,[2] a self-report instrument, assesses whether people have internalized society's stigmatized views. Four subscales are included in this scale, which reflects the four stages of stigmatization internalization, as described by Corrigan et al[2]: (1) knowledge of stigmatic views concerning mental illness, (2) acceptance of the stigmatic views, (3) projection of the stigmatic view into self-identity, and (4) reduction in self-esteem. There are ten statements on each subscale, and participants are asked to rate each on a Likert scale from 1 (strongly disagree) to 9 (strongly agree). The total score for each subscale ranges from 10 to 90, with higher scores reflecting higher adoption rates as indicated by the respective subscale. A high degree of internal consistency was observed in the current study (knowledge of stigmatic views: $\alpha = 0.90$, accepting the stigmatic views: $\alpha = 0.94$, projecting the stigmatic view into self-identity: $\alpha = 0.85$ and a reduction in self-esteem: $\alpha = 0.87$). Results were considered significant at $P < 0.05$.

Then, we assigned the participating patients equally into

experimental and control groups, with 26 patients in each group. Two days a week for 90 minutes, the experimental group received English language instruction for 24 weeks. During this experiment, experimental group was instructed using the Oxford university press textbook, New Headway (beginner), written by Liz and John Soars. We used the New Headway, to practice grammar, vocabulary, and language skills (listening, speaking, reading, and writing) while engaging the learners in communicative role-plays and personalizing the experience. The book helped the students practice the English language in context with authentic material from different sources. Different comprehension activities, language exercises, and communication activities reinforced the four skills of listening, speaking, reading, and writing. In several sections, the learners practiced speaking and written communication skills in a real-world environment. A total of 48 sessions were spent teaching the six units in the book.

The pre-test and post-test contained different questions to avoid repetition effects. Three authors of the paper had agreed on the study's pre-test and post-test before it began. A post-test was conducted to measure the degree of improvement in each learner's English-language proficiency at the end of the implementation period. In addition, both groups completed a self-stigma questionnaire. The researchers collected the data and analyzed them directly. The only difference between the experimental and control group was teaching the English language to experimental group patients.

Results

As presented in Table 1, there was no significant difference in mean scores for English language proficiency in the pre-test of the control and experimental groups ($P>0.05$). Independent t-tests (Table 2) affirmed significant gains in English language proficiency of the learners in the EG group in the post-test ($P<0.01$). The effect size was effect size (ES) = 6.95 and r = 0.96.

Paired samples *t* tests revealed that learners in the experimental group had significant improvements in English language proficiency in the post-test. The effect size was ES = 7.32 and r = 0.96 ($P<0.01$). Additionally, the control group learners had no gains in English language proficiency ($P>0.05$). Tables 3 and 4 indicate the results of paired samples *t* tests.

The research hypothesis predicted that English language instruction would significantly differ between the groups based on stigma. As presented in Table 5, there was no significant difference in the mean scores for self-stigma in the pre-test of the control and experimental groups ($p>0.05$). Independent t-tests (Table 6) affirmed significant gains in stigma reduction for the patients in the experimental group in the post-test ($P<0.01$). The effect size was ES = 14.73 and r = 0.99.

Paired samples *t* tests revealed that learners in the experimental group had significant improvements in stigma reduction in the post-test. The effect size was ES = 8.28 and r = 0.97 ($P<0.01$). Additionally, the control group students had no gains in stigma reduction ($P>0.01$). Tables 7 and 8 indicate the results of paired samples t-tests.

Discussion

Instructing mental health patients in the English language led to a great deal of change in English language proficiency and the stigma they face due to mental disorders. The findings of this study provide theoretical support for Norton's[1] investment model and demonstrate its applicability among people with mental problems. Furthermore, the study proves that English language teaching can be implemented successfully among patients with mental disorders, which has not received adequate attention in academic studies.

The experimental group's higher performance is consistent with Staudinger and Kunzmann.[44] They found that individuals change or develop when they face and try to adapt to new life experiences (in this case, second or foreign language exposure), which dramatically affects their social-emotional growth and can lead to successful social interactions. Ghaznavi et al[45] and Golshanet al[46] found successful English language training accompanied by some positive changes in learners with special needs, which is in line with our findings.

Since investment with a sociological view considers a significant connection between a learner's passion and engagement in learning a language and their dynamic identity,[1,47] this study demonstrates how patients' stigma, which is potent and changeable across time and space, has been impacted by English language learning. Learning

Table 1. Independent *t* test of English language proficiency (pre-test)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Language proficiency test	Control	26	2.69	1.74	-0.52	50	0.60
	Experimental	26	2.92	1.44			

Table 2. Independent *t* test of English language proficiency (post-test)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Language Proficiency Test	Control	26	2.65	1.72	-25.10	50	0.00
	Experimental	26	15.15	1.87			

Table 3. Paired *t* test of English language proficiency (control group)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Language proficiency test	Pretest	26	2.69	1.74	0.73	25	0.94
	Posttest	26	2.65	1.72			

Table 4. Paired *t* test of English language proficiency (experimental group)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Language proficiency test	Pretest	26	2.92	1.44	-30.20	25	0.00
	Posttest	26	15.15	1.87			

Table 5. Independent *t* test of self-stigma (pre-test)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Self-stigma	Control	26	36.81	1.94	0.10	38.10	0.9
	Experimental	26	36.73	3.65			

Table 6. Independent *t* test of self-stigma (post-test)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Self-stigma	Control	26	37.04	1.75	53.09	50	0.000
	Experimental	26	13.88	1.37			

Table 7. Paired *t* test of self-stigma (control group)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Self-stigma	Pretest	26	36.81	1.94	1.29	25	0.2
	Posttest	26	37.04	1.75			

Table 8. Paired *t* test of self-stigma (experimental group)

Variable	Group	N	Mean	Standard deviation	T test	df	P value
Self-stigma	Pretest	26	36.73	3.65	29.51	25	0.00
	Posttest	26	13.88	1.36			

a new language is a complex process that includes the entire person, physically, intellectually, and emotionally. Patients (language learners) in this experience oscillated between comprehension of themselves as speakers of their first language (L1) and an awareness of themselves as learners of a second language (L2), in terms of how they 'identify' themselves. As a result, identity development through language use is thought to be a multilayered, non-stop, and dynamic process[48] Furthermore, it is considered that language is vital to both human cognition and condition, identity building, and self-development.[49] In line with our findings, Norton[50] proposed that language both shapes and is shaped by one's identity. Furthermore, it is widely acknowledged that language learning and identity reconstruction are inextricably linked,[30,35,49-51] though discussions of identity theory rarely fall directly under the umbrella of SLA research.[52]

Thornicroft et al[53] reported that social interaction is among the most effective interventions for improving stigma-related knowledge and attitudes in the short term, which confirms our findings. According to Sewilam et al,[54] stigma reduction tactics differ depending on contextual elements such as politics, social level, culture, religion, and media. Therefore, studies of context conditions and appropriate techniques are needed to examine English language learning among patients with mental disorders in other cultures and contexts.

Conclusion

The current study adds to our understanding of English language teaching and learning in the medical field. The findings support second language teaching to reduce stigma among those suffering from mental illnesses. This is a starting point of a journey, and more study is needed to delve into the complexities of English language acquisition and how it can accelerate the improvement and rehabilitation of people suffering from mental illnesses. Language plays a crucial role in establishing one's social identity and distinguishing oneself from others. Similarly, identities can be imposed by the language used, and language users may modify their language usage to fit in with a dominant group's social identity.[55]

It is essential to mention some limitations of the current study. Individuals with diverse diagnoses were combined into one diagnostic category to simplify the analysis because the study encompassed such a broad range of mental disorders that it could not detect differences between the same groups of patients. Larger sample size and more specific diagnostic categories are necessary for future research. Moreover, the convenient nature of the sample used in the current study limits the possibility of the findings' generalizability to a larger population. Stigma toward mental illness differs from culture to culture.[56] Future studies can show the diversity of stigmatic views across cultures.

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Authors' contributions

All authors contributed to the research design, data collection, drafting, and revisions.

Competing interests

The authors declared no competing interests.

Ethical approval

The participants and their families were informed of the purpose and procedure of the study before the project began. A regional hospital responsible for the patients' welfare approved the program's ethical considerations. Participants remained anonymous, and their data were confidential.

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