Medical Staff Social Practice and Attitude towards People with Mental Disorders

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Abstract: *Background*: Considering the social vulnerability of the people with mental disorders and a certain dualism of treatment practice within this social category of people and beginning from socializing process to isolation in Ukrainian society, it becomes relevant to prevent the formation of antisocial and stigmatizing consequences toward the patients with mental disorders in society.

Objective: The article's aim involves the social practice of studying and attitude toward patients with mental disorders. They are based on the results of sociological questionnaires.

Methods: The questionnaire is based on psychiatrists and psychiatric hospitals' medical staff surveys. It covers 505 medical workers of the Regional Clinical Psychiatric Hospital in the Zaporizskiy region of Ukraine.

Results: The result points to the domination of neutral attitude toward the mentally disabled people among the respondents-experts (medical and junior medical staff including), which in turn causes several negative consequences as follows: lack of understanding of treatment differences concerning the mentally healthy and mentally ill; a latent reluctance for changing the social treatment practice towards the mentally ill in a more humane way; distancing from the mentally ill; a change of verbally-behavioral practice to antisocial, hostile ones. etc.

Conclusions: Despite the globalization of the modern world, the local composition of verbal-behavioral social practice toward people with mental disorders is influenced by socio-cultural, economic, and political determinants.

Keywords: Mentally ill, social practice, stigmatization, isolation, integration, physicians and medical staff.

INTRODUCTION

Nowadays, in Ukraine and the CIS countries, a radical reformation of the health care system takes place, significantly reducing patients' access to specialized medical care, respectively. The mainstream of this reformation process is to strengthen the inclusive and integrative components in the psychiatric community's attitude. Moreover, the society's attitude towards the people with mental disorders, which in turn contribute to such people's (with mental disorders) full-functioning, comprehensive rehabilitation, readaptation, tolerance, and social dignity gaining [1-3]. Since psychiatry is considered one of the most specific social institutions, the greatest changes are observed in psychiatric, psychotherapeutic, and medical-psychological care. Therefore any institutional reforms in psychiatry are impossible without understanding and general awareness of the processes within the social treatment practice toward the mentally ill individuals.

The article aims to study attitudes and social practices towards people with mental disorders (based on a sociological survey provided among the medical staff of psychiatric institutions). In this case, a so-called sociological analysis of social practice towards the mentally ill will helpfully open the features and patterns, which contribute to eliminating existing negative trends, predicting the emergence, and timely avoiding discrimination, exclusion, social isolation, and stigmatization the mentally ill individuals.

This sociological analysis of social practice toward the mentally ill plays a vital role in the reproduction and institutionalization of Ukrainian psychiatry and forming a psychiatric community. It prevails stigmatizing, socially isolating, and discriminatory treatment practices regarding the people with mental disorders whose culture reflects the Post-Soviet historical period, double treatment standards, and cognitive treatment models, which draws up the general hypothesis of the given study.

Following the purpose and objectives of the given study, social practice toward people with mental

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disorders is defined as routine models of institutional procedures and daily social actions, with appropriate technologies of the influence on the mentally ill as a special social group. Social groups and institutions that implement appropriate behavioral practice relative to people with mental disorders include, 1) a family; 2) small groups of a contact microenvironment (caregivers, social workers, etc.); 3) social work services; 4) law enforcement agencies; 5) psychiatry as a social institution (psychiatric hospitals, psychiatric faculties, and departments of medical universities, individual psychiatrists as the subjects of medical activity (within public and private psychiatric hospitals); 6) institutes of re-socialization and rehabilitation (rehabilitation centers, mental retardation centers, prophylactics, etc.); 7) mass media.

Due to the availability of data on the negative impact of incorrect and distorted information concerning the field of social practice towards mentally ill individuals, the feasibility issue of depriving specialized information about the field of psychiatry outside the framework of the employees of the specialized educational fields is arising now. On the one hand, the state, implementing regulatory policy in the field of medicine and penitentiary profile, delegates its functions to specialized institutions: hospitals, labor camps, including specialized mental hospitals. On the other hand, a family as a social institute ceases to adapt to the self-detention of the mentally ill, delegating the roles of caring to the agencies of guardianship and tutorship, law-enforcement agencies, and specialized treatment institutions. It's evident that in the internment process, an individual's legal status changes who was previously recognized as a legally incompetent person due to the circumstances of his/her mental disability (a given individual alienates from a family circle, has no possibility for controlling and managing revenues).

MATERIALS AND METHODS

Speaking about the period of their appearance, D. Reed identified three main motives for isolation and distancing society from the mentally ill:

1) economic motives (related to the possibility of compelling hospital patients to forced labor for a paltry compensation);

2) political motives (related to the need of isolating political marginals and radicals to prevent protests, which was carried out under the guise of helping the sick and poor);

3) moral and ethical motives (psychiatric isolation was used to strengthen the morality of labor obedience and disciplinary guidelines in the structure of the social nature of employees) [4,5].

Thus, it can be argued that the practice of treating people with mental disorders in the form of distancing and isolation existed long before the definition of "the mentally disable" but retained its former social significance.

As in most countries, the provision of medical aid to people with mental disorders is regulated by the laws on psychiatric care. In Ukraine, the Law "On Psychiatric Care" was adopted on February 22, 2000. It established three types of psychiatric care: psychiatric examination, outpatient psychiatric care, and inpatient psychiatric care [4].

Considering the difficult economic situation of the state and almost zero amount of its material assistance, people with mental disorders are condemned to precarious material existence and financial dependence on the state and third parties [5]. On the other hand, Article 9 provides restrictions related to the performance of certain activities, which, of course, provokes the patient to hide the disease's existence and not seek professional care services. Thus, a paternalistic behavioral attitude toward people with mental disorders is realized, which results in their unemployment and the absence of certain material assistance.

For the people with mental disorders, who have committed socially dangerous offenses, the practice of coercive measures of a medical nature in the form of outpatient care or hospitalization to a certain psychiatric institution with normal, intensive, or strict supervision is used. Thus, the social practice of distancing regarding the mentally ill who have committed socially dangerous offenses is legitimized by healthy criminals. At the same time, the necessity of certainty of punishment is being recognized, and a specialized system of medical institutions is being created [6].

The beneficiaries of social practice and attitude toward the people with mental disorders, who have completed and are reliable in specialized information about mental regulations and pathology, including physicians specialized in psychiatry. Partial possession of the technical knowledge about mental regulations and pathology is noted by non-psychiatric doctors,

medical psychologists, representatives of pharmacological companies. The subjects of social practice and attitude toward mentally ill individuals, who do not possess technical information or its amount, are paltry, including employees of social organizations, scientific and educational institutions of non-medical character, general psychologists, and the rest of the population. It is rational to include people with mental disorders and their family members in the same category. Despite the direct experience of mental disabilities as a problem, the mentioned group of people have mostly subjectively-determined information rather than a specialized one [7].

Survey Development

Study Design

A questionnaire-based survey of psychiatrists and paramedical personnel of psychiatric hospitals on the topic, "The Problem of Adaptation of the people with mental disorders and Attitudes Towards them" was produced. The purpose of the study was to assess verbal-behavioral practice and attitude toward mentally disabled persons by the staff of psychiatric hospitals.

Subject and Population

The main objectives of the study are:

- to identify the opinions of respondents on stigmatizing, discriminatory, and inclusive technologies attitudes towards mentally ill individuals;
- to characterize the professional ideas of the psychiatric community as one of the factors in the formation of exclusive social ideas towards mentally ill individuals;
- to analyze the practice of double standards attitudes towards mentally ill Individuals by the psychiatric community and in the society itself;
- to determine the level of demands and tolerance towards the mentally ill and the probable social attitude toward them in the psychiatric community and society itself.

Working hypotheses of the given study are based on:

1) the proximity of the percentage of respondents with a negative attitude towards the people with mental illnesses and the percentage of respondents who consider the people with mental disorders the same people who suffer from other ordinal diseases;
2) an ulterior exclusion, provided that the discourse and social practice toward the people with mental disorders is inconsistent;
3) the discursive models of the psychiatric community as one of the factors in the formation of exclusive social ideas about the people with mental disorders and relevant technologies toward people with mental disorders, including the isolation and stigmatization processes;
4) the gender conditionality in the treatment of the mentally ill and the predominance of double standards of evaluation;
5) the discrepancy between the verbalized commitment to the use of inclusive technologies and the actual use of exclusive and discriminatory practices, which are among most of the respondents.

A questionnaire survey of psychiatrists and support staff of psychiatric hospitals was conducted in December 2020. In total, n = 505 persons or employees of KU "Regional Clinical Psychiatric Hospital" ZOR were interviewed. The criterion for selecting questionnaires for inclusion in the study was the following position: a psychiatrist, a nurse, a junior nurse. The basic criterion for the questionnaire selection included in the given study were the positions of a psychiatrist, a nurse, and a junior nurse. Four hundred twelve of the respondents answered all the given questions being put, which is equal to 81.58% in general and ensures the sample representativeness of the psychiatric community.

Survey Development/Instruments and Interpretation

Methods of individual questionnaire dissemination and receiving back the filled questionnaires by e-mail, moreover, filling in paper questionnaires by respondents were used to obtain certain sociological information. In order to test the given hypothesis, the research questionnaire presents a set of responses to which the members of the psychiatric community may overlap and which might reveal the attitudes toward the stigmatization-exclusionary and inclusive practice of treating mentally ill people who possess mental disorders in some cases. The given questionnaire was made by the authors of the article.

Data Collection and Statistical Analysis

A questionnaire survey was conducted based on KU "Regional Clinical Hospital" ZOR. This medical institution was chosen as the place of the survey because it is a typical medical institution providing psychiatric services in Ukraine.

The distribution of responses, based on the territorial and settlement characteristics, was carried out as follows:

- The responses of people, born and lived in the village to adulthood, graduated from high school in the countryside, we counted to the villagers' point of view. However, today they live in Zaporizhzhia, the regional center, because their personality and worldview were formed under the impact of the countryside areal life.
- The responses of people, born and lived in a small town of non-regional type to the adulthood, graduated from high school in a small town, we identified as the opinion of residents of a small town, but today they live in Zaporizhzhia, though, as far their personality and general worldview were formed under the impact of the urban-type settlement. All respondents, who indicated the availability of higher education, 21.6% in total, possess a higher education degree. However, only 16.9% of them noted the availability of higher medical education as follows. Therefore, the sample structure differentiated by professional, territorial-settlement, gender, and age characteristics is given in the Table **1-4** below.

Table 1: The Selection of Structure by an Occupational Characteristic

Occupation	Research groups (n = 505)	
	Persons	%
Psychiatrist	86	17.0
Nurse	388	76.8
Junior nurse	31	6.2

Ethics Approval and Consent Statement

The Ethics Committee approved the survey of Municipal non-profit enterprise "Regional clinical institution for psychiatric care" of Zaporizhia regional council. This study was carried out as per recommendations following ethical standards. No bio-markers or tissue were collected. Participation was entirely voluntary, confidential, and anonymous. Before filling out the survey, which was self-administered anonymously, all participants were asked to give written online informed consent, as legally and ethically required.

Table 2: The Selection of Structure by an Educational Characteristic

Level of Education	Research groups (n = 505)	
	Persons	%
Higher	109	21.6
Specialized secondary education	386	76.4
Secondary education	10	2.0

Table 3: The Selection of Structure by Settlements Characteristic

Settlements	Research groups (n = 505)	
	Persons	%
Village	30	5.9
Urban village	11	2.2
A small town	253	50.1
Regional Center	211	41.8

Table 4: The Selection of Structure by a Gender Characteristic

Gender	Research groups (n = 505)	
	Persons	%
Men	104	20.6
Women	401	79.4

For data analysis, we use descriptive statistics analysis. Statistical analysis involves data processing using SPSS 19 programs. If people with mental disorders ignore specific rules of cohabitation and refuse to perform their usual daily duties, respondents agreed to apply medical and repressive measures to them. For instance, about 35% of respondents agreed to increase drugs and hospitalization for people with mental disorders. At the same time, the majority, almost 65-72% of the liberal group of experts, consider such manifestations to be a common phenomenon rather than a particular form of mental health disorder.

RESULTS

The study found that the respondents interpreted the phenomenon of mental health disorders differently.

75.6% of respondents believe that mental disorders are the same disease as any other; 10.0% of respondents believe that such mental disorders do not exist. It is a conventional type of pathology, which identifies one individual from the others. 9.7% of respondents think that it is the result of mystic powers, such as gods, spirits, evil eye, etc. 3.7% of respondents state that this is the result of a global control mechanism of human civilization is generally biological and environmental contexts.

There are also no obvious differences in views on the definition of mental disorders by age, gender, place of residence, and the birth of the medical staff.

In the XXI century, in Ukraine, almost 10% of psychiatric hospital staff believe that mental health disorder results from mystic powers. This fact is drawing the attention of many scientists. At the same time, no reliable dependence has been established between education and the chosen option. Namely, the options, contrary to purely medical understanding of mental disorders, are chosen by junior medical staff and doctors approximately in the same percentage. Firstly it demonstrates the insufficient educational level of the medical staff of psychiatric hospitals, which can affect the social practice and attitude towards the mentally ill during the process of their medical care. Secondly, it demonstrates the persistence and stability of magically-religious views among the respondents even involved in the profile -medical-scientific sphere.

Attitude to the Disease Prediction

There are various attitudes toward predicting diseases. Thus, the majority of respondents (49.1%), based on their observations, believe that mental disorders are completely incurable, in their perception, a person, who has been diagnosed with a mental disorder at least once in his life, will never get rid of the given disease; 31.4% stated that mental disorders are generally curable, but their individual manifestations remain, and only 14.0% agreed that a person with a mental disorder could be completely cured.

In the medical literature, the mental disorders of the neurotic character are identified as those that can be quickly and completely cured. Only mental disorders of endogenous and some exogenous genesis are considered incurable. Contrary to the official position of modern medicine, we have reason to state the existence of prejudice towards the curability of mental disorders among almost half of all employees of psychiatric hospitals. Medical staff is subconsciously showing indifference to the mental disorders of hospital patients, who are automatically "labeled" as having an incurable psychiatric disease.

Female respondents, including psychiatric doctors and support staff, have a more pessimistic view concerning mental disorders' curability than a male part has (54.3% and 46.7%, respectively). Variants of the persons surveyed by position (doctors, nurses, junior medical staff), residence, and birth did not reveal a significant relationship between the groups.

Appropriateness of the Interpretation of Mental Disorder Symptoms

The analysis of empirical data revealed a distorted perception of the mental disorder symptoms by the medical staff of psychiatric hospitals and the tendency

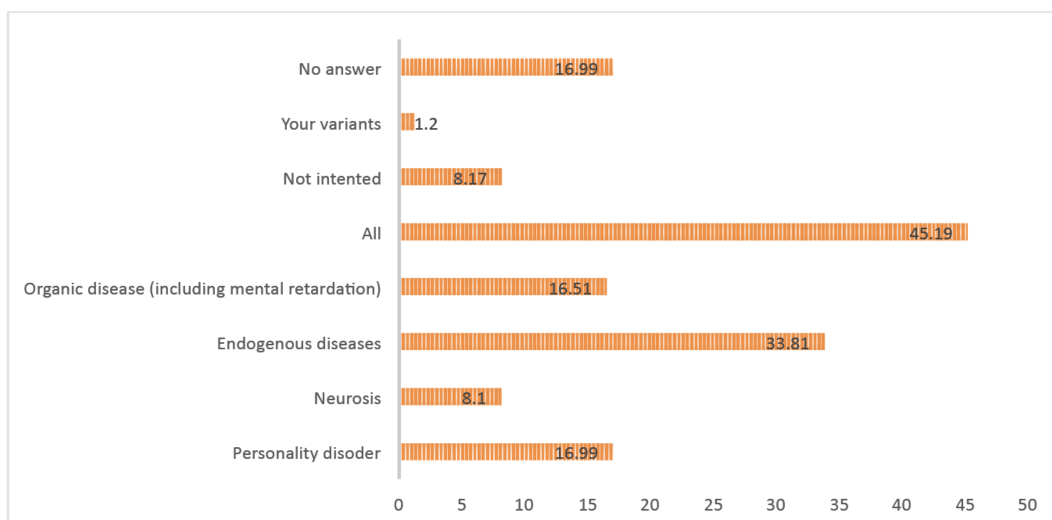

Figure 1: Types of mental illness. Total 624 (96.8%) respondents surveyed/ 604 answered.

to project the given disease manifestations on unrelated social actions made by the people with a mental disorder. The majority of respondents, 69.0%, respectively tend to consider it an unambiguous demonstration of a mental illness rather than a characteristic typical for most healthy people. And only 35.0% of respondents agree that it is not necessarily to manifest the given psychiatric disorder. The following described the situation, where a person with a particular psychiatric diagnosis ignores the dormitory rules, such as refusing to wash the floor, wipe the dust, returns home late, etc.

Moreover, only 36.6% of respondents believe that the violation of the rules of the dormitory should not result in increasing the dose of medication or lead to further hospitalization, while other 32.4% believe that a basic refusal to wipe the dust is at least leading to a person to be prescribed a higher medication dose, as a maximum, to be hospitalized in a psychiatric hospital. At the same time, there is a relationship between education and distorted perception of mental disorder manifestations and treatment regulations. Thus, the majority of doctors (65.2%) and nurses (66.2%), on the one hand, tend to exaggerate the importance of social actions of the patient, interpreting it as psychiatric disorder manifestations; only 72.4% of respondents among the junior medical staff, tend to underestimate the manifestations of the illness, on the contrary.

The Role of the Mentally Ill in Society

Assessing the role and place of the people with mental disorders in society differs considerably among certain socio-professional subgroups of psychiatric institutions' employees. Thus, 39.2% of psychiatric hospital staff believe that the mentally ill are a global burden of society; 22.8% acknowledge that mentally ill individuals are the object or way of receiving benefits from other people (including economic, political, psychological benefits).

However, a significant number of respondents (38%) have a better opinion of the mentally ill: for example, 23.5% of psychiatric hospital workers believe that the mentally ill are the factor of influencing the history, culture, and science development, thanks to prominent personalities who belong to this group of people; on the other hand, 7.7% - consider the mentally ill as the main generators of the progress ideas, as far their individual fantasy is the driving force for carrying out various activities; and at least 6.8% - believe that the mentally ill are the conductors of so-called higher powers, they have some secret gift – are able to predict the future, treat and so on.

Paradoxically, but a large group of respondents (37.7% respectively) with higher education believe that mentally ill individuals can be committed to higher powers and have a special secret gift for predicting the future, treating people, etc. At the same time, the respondents with secondary and special secondary education consider the mentally ill as a burden for the given society (60.0% and 56.3%, respectively).

Compulsory Psychiatric Treatment

The issue of compulsory psychiatric treatment, being a sensitive topic in psychiatry, also demonstrates variability and divergence of views among psychiatric medical staff, where a compulsory treatment and denial of the patient's right of "not to be treated" are supported by most of the respondents.

Therefore, 85.5% of respondents believe that persons with a psychiatric diagnosis should be treated, but such persons do not have the right to choose to be treated. On the other hand, 10.6% believe that the mentally ill have the right to decide independently: to be treated or not, while only 3.8% noted that each case has a distinct approach.

The majority of respondents (88.6% respectively) denied the right of the mentally ill not to be treated, even though a mentally ill person does not want to take the treatment recommended by a psychiatrist. 46.9% of the given respondents support the practice of hospitalization of a patient who does not want to take medication at home. 11.6% insist on compulsory outpatient treatment executed by a court. 6.6% believe that the patients should be forced to take medication, and 23.5% of respondents even allow the possibility of pouring drugs into food secretly.

Thus, it is evident that a significant number of medical staff in psychiatric institutions do not even allow a compulsory form of psychiatric care to be applied. Moreover, consider it appropriate to use socially unacceptable, immoral, and even illegal practices against the mentally ill.

Only 11.3% of respondents pay close attention to the wishes of patients. 7.6% adhere to the position if a patient does not want to be treated. This person should be left alone ("let him not be treated"). 3.7% believe that the patient should be allowed to be treated the way

he likes, including using alternative medicine methods (herbal medicine, traditional healing, etc.).

At the same time, the majority of respondents who belong to the medical staff of psychiatric hospitals (93.3%) stick to one opinion on the issue of compulsory treatment and recommended hospitalization of their relatives who deny taking compulsory medication. 49.5% will hospitalize a relative who does not want to take treatment at home. 23.5% assured that they would secretly add drugs to food. 10.8% will insist in court on applying compulsory outpatient treatment. 9.7% are ready to force a relative to take drugs. Only 6.5% agree to heed the patient's views: 4% among them agree to leave a relative without a particular specialized treatment. 2.5% - will treat a relative in the way he approves, even if this treatment is not supported by classical medicine (by herbs or healers, etc.).

Considering the issue of psychiatric treatment, the medical staff of psychiatric institutions is more demanding and insists on compulsory psychiatric treatment. At the same time, it is being referred to their relatives: 93.3% would insist on denying the right of their relatives not to be treated. Thus, it is 4.7% higher than the number of employees who would force the third-party patients to be treated.

The Adjustment Need of the Society's Attitude Toward Regarding the Mentally Ill

Opinions concerning the "need to change practice" in treating the mentally ill are almost halfway divided. 49.09% of the respondents surveyed believe that we should not change our usual behavior while communicating with the mentally ill. Society models of treatment for the mentally healthy and mentally ill should remain the same. However, 41.99% of respondents hold the contrary view and believe that mentally ill people should be treated the same as the mentally healthy.

Thus, the majority of doctors (63.2% respectively) have a more tolerant attitude regarding people with mental disorders and support applying equal behavioral models between the mentally ill and mentally healthy. In contrast, most junior medical staff (55.2% respectively) were inherently biased against the mentally ill and insisted on the need to change the behavior while contacting mentally ill individuals.

Thus, the view on the need to differentiate between social practice towards the mentally ill and mentally healthy is in most cases supported by those respondents who consider mental disorders to be more unpleasant diseases for their carriers (64.60%) and the environment (53.50%) than somatic diseases. Whereas, the indistinguishability tactics of social treatment practice towards the people with mental disorders and mentally healthy are mainly supported by those respondents who do not pay much attention to the difference between mental and somatic disorders (61.00%). These respondents consider the mentally ill as normal people with particular features and consider that mental illness does not distinguish them from healthy (58.1%) (X2 =19.939).

The majority of respondents, who support the behavioral practice toward the people with mental disorders, 71.50%, advocated against the establishment of unreliable, "softer diagnoses", which are reconciled with the attitude of respondents to the given treatment-way situation in general. The behavior of these respondents directly reflects the identified diagnosis of the patient given. Thus, one (the same) of the respondents advocate for reliable diagnostics in order to be able to correct their own behavior towards the carriers of a particular psychiatric diagnosis.

At the same time, almost half of the respondents (46.40%), who advocate for changing the attitude of the given society to the people with mental disorders, assure of their psychiatric hospitalization while observing the fact of having some mental illness. They will not hide the fact of the disease and are ready for the actual society changes in the behavior towards them. Being in a similar situation, 14.20% of respondents, who advocate the absence of the necessity to change behavior toward the people with mental disorders, will appeal for assistance rather from non-specialists, a neurologist or a therapist respectively, than from a psychiatrist. Compared to 9.20% of respondents, who advocate for changing society's attitude toward people with mental disorders, they vote for other specialists. This fact directly indicates the root cause of such a position: people, who tend to endorse the lack of society's behavioral change toward the people with mental disorders, are more prone to misunderstand mental disorders, even in terms of their specialization.

More than half (58.9% respectively) of those respondents who claim the need to change the practice of dealing with the mentally ill admit non-compliance with the corrective behavioral change in relation to the people with mental disorders in everyday life. And only 41.10% of respondents change their behavior while

contacting people with mental disorders: 16.70% of them try to avoid direct contact with people with mental disorders. 22.1% of them treat people with mental disorders in a more polite way than the mentally healthy in such situations, and only 1.20% demonstrate a hostile attitude to the mentally ill in verbal and non-verbal forms of behavior (X2 =11.701).

Thus, those respondents who advocate for the social practice changes regarding the people with mental disorders are assured of the domination of a negative emotional perception of the people with mental disorders in the society (87.40%). Predominant emotions associated with the people with mental disorders in the society, which have been named by most of the respondents, are the following: "fear" (63.00%), "contempt" (34.60%), "indifference" (34.30%) and "hatred" (20.90%). This explains the tendency to change the established social practice of treating the mentally ill to more friendly ones.

It is interesting to observe that almost half of the respondents, who insist on the absence of the treatment differentiation toward the mentally-healthy and mentally ill people (46.20%), and almost the same number of respondents, who support the need for distinctions in behavior patterns toward the people with mental disorders (53.20%), support the social isolation methods in relation to the mentally ill under certain circumstances (X2 = 7.956).

The next research will analyze some intergroup comparisons between different professions.

DISCUSSION

Social practice is one of the basic concepts in sociology. Their study is possible through certain verbal acts and social actions. The importance of verbal-behavioral social practice is attributable to their impact on the objects of social life and the construction of the interaction of social groups in general. In this context, it seems important to study the social practice of attitude/treatment of certain social groups, especially the people with mental disorders, in modern society [9].

Visual representation of participants in social practice regarding mental disabilities, depending on the share of possession of reliable specialized information on mental disorders, norms, and pathology, is given in Figure **2**.

Empirical studies are primarily focused on stigmatizing practices toward mentally ill individuals. Certain progress in implementing new treatment and diagnosis methods and giving thanks to the hope of society and its patients themselves for recovery and re-

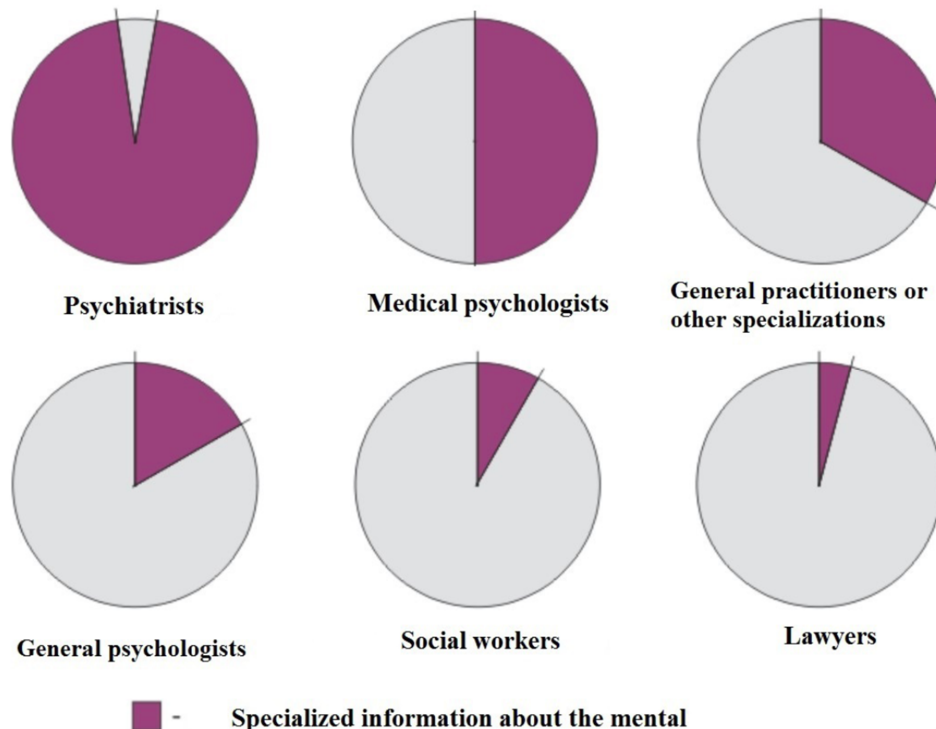

Figure 2: The subjects of social practice in the treatment of mental disabilities depend on the percentage over possession of reliable specialized information about mental disorders, mental regulations (norms), and pathology [8].

socialization of this social group made the problem of stigmatization relevant nowadays. Effective treatment makes it possible to eliminate the medical causes of deadaptation. However, patients continue to experience difficulties in society. They tend to social deadaptation not due to their disease, but firstly because of already-existing negative stereotypes, attitudes, and behavioral treatment patterns toward the mentally ill group of individuals [9,10].

Psychiatry is an institutionalized variety of social practice and models of interaction between people with mental disorders, who are the bearers of specific habit and society on one hand. But on the other hand, it is methodologically focused on such areas of modern sociology as the structural constructivism by P. Bourdieu (study of psychiatric discourse as a component of a culturally-symbolic idea production which legitimize certain social practices) [11,12].

The A. Giddens's theory of the duality structure position is represented as a recursive action, which does not only create limitations, but also expands the possibilities of hospitalizing, repressive and inclusive functions of psychiatry, respectively [13], the theory of stigmatization by G. Becker, K. Erickson and E. Lemert. The given theory concerns the subjects of medical branch of power, which have the opportunity to hang negative labels and carry out a negative socio-normative categorization of the mentally ill [14].

The researchers' opinions mentioned above in the context of the chosen topic are responding to the idea of understanding psychiatry as a specific institutionalized form of social practice, which constitutes the basis of social processes such as interaction - integration/disintegration, inclusion/ exclusion, re-socialization rehabilitation/repression-prevention. And it remains one of the most significant and relevant problems in modern society and various social group modeling, including the people with mental disorders. Therefore, the relevant social treatment practice toward the people with mental disorders. It is either isolation-stigmatization, or valorization, or integration, which are mainly derived from what is called by C.J. Geertz “the concept of man in culture” [15, p. 43-67].

According to C.J. Geertz's "concept of man in culture" and culture as a programming language of relevant practice, there follows a model of social structure, which, in fact, on the one hand, structures individual practice. On the other hand, it is their product. The structuring of practice as parts of the social structure and the formation of the certain unity, for example field-practice, is conceptualized in other theories such as the P. Bourdieu's structural constructivism, A. Giddens' structuring theory and H. Garfinkel's ethnomethodology [16]. We will try to dwell on them in detail.

P. Bourdieu analyzes social practice as a certain ability of social subjects to check their behavioral acts to comply with the formed social ideas about reality.

The author defines the practice as an action that contributes to the transformation of the social world, and as a daily everyday activity, on the other hand, which needs no explanation and seems to the outside observer meaningless, as illogical [11].

P. Bourdieu has transmitted a very important category of habit needed to understand the social practice, which he defines as a precondition to the "structuring the structure" of practice, ensuring sustainability and clarity, which generates practice and ideas [12, p. 102].

In accordance with the given study, a habit can be considered a product of history, and acquired (internalized) system for generating schemes, and a combinatorial matrix for developing an infinite number of practices [12].

The habit of the psychiatrist is formed as a part of the social culture, which reproduces certain explanatory schemes for understanding mental illnesses. For A. Giddens, social practice is the basis for forming both the subject and the social object [13]. All social practices are considered to be structure-forming and structure-forming social actions, taking place in certain social continuums: space and time. They are tied to a certain institutional context and social group background. A. Giddens emphasizes the sign of "uncreativeness of social practices" by social actors agreeing with him. Actors do not produce practice, but it is only reproduced. They are a mesolevel entity in terms of structures and subjects, social totality, and experience of individual origin. Using the conceptual structuring theory, A. Giddens names social practice as «routines», meaning habitual actions corresponding to everyday social activities [13].

Routines cease to be realized, which forms the area for the habitual perception of certain images. Treatment practice toward people with mental disorders also takes the form of routine. Thereby the discrimination,

humiliation, and torture of dependent persons on the medical staff are often not noticed.

In accordance with the purpose and objectives of the given study, we define social treatment practice in relation to the mentally ill individuals as routine models of institutional procedures and day-to-day social actions that constitute the structural factors of social discourses and institutions with the immanent technologies to influence the mentally ill as a special social group [17, 18].

Consequently, despite the fact of the globalization of the modern world, the territorial composition of verbal-behavioral social treatment practice toward the people with mental disorders is influenced by social and cultural, economic, and political determinants of the supranational and state levels.

Medical and psychological care-area are also included). Thus, we can talk about the possibility of analyzing and evaluating practice with the help of sociological tools, which allow solving the problem of their uncontrolled, negative transformation and appearance of detrimental effects on the health care system such as psychiatric, psychotherapeutic. Hence, the obtained data confirms the possibility of developing certain schemes and methods of prevention and influence on verbal-behavioral social treatment practice toward the people with mental disorders to achieve their optimal mental condition.

The difference from the results of the previous research consists in the possibility of the presented model to reveal the advantages of assertive rehabilitation as a technology of inclusive psychiatry, which is based on re-socialization processes outside the hospital and continuous inclusion under the principles of the institutional and informal practice of psychiatric outpatient care.

It is worth noting three areas of psychiatry's social and institutional reformation processes in Ukraine: the first area includes institutional reformation of psychiatric hospitals by incorporating inclusive technologies into the treatment process in relation to the people with mental disorders in the existing psychiatric institutions. The second direction includes the creation of alternative, of course, non-medical by their profile, social institutions, subsidiary to the psychiatry as an individual social institution. They may be general medical clinics, providing anonymous psychiatric care on an outpatient basis. The third direction, in addition to the above, provides an alternative to psychiatric hospitals in the form of an assertive treatment: a set of service measures, support, training, and prevention work; implementation of a number of social and supportive actions, which should reconfigure people with mental disorders from the isolation-exclusive to integrative or inclusive methods of behavior into society.

The goal of the article has been achieved. The facts represented above demonstrate the significant preconditions for the emergence of the social stigmatization environment towards mentally disabled patients in the form of distancing. The root causes consist of the declared practice of medical representatives of psychiatric institutions in Ukraine. This aspect needs to be appropriately adjusted by carrying out the specialized thematic dialogues and classes for medical staff by introducing an appropriate frame filtering/lustration system during the recruitment process to the specialized psychiatric institutions in Ukraine.

LIMITATIONS

The questionnaire was conducted in one hospital only, KU "Regional Clinical Hospital" ZOR. This medical institution was chosen as the place of the study because it is a typical medical institution providing psychiatric services in Ukraine.

The study lacks intergroup comparisons between different professions, which will be analyzed in the subsequent research.

CONCLUSIONS

Concluding, we must clarify the most common types of social practice and attitude to people with mental disorders among the group of medical representatives of the psychiatric specialization are as follows:

- lack of understanding of the difference of attitude to the mentally healthy and mentally ill. More than half of the respondents stick to this particular model of the indistinguishability practice;
- the latent reluctance for changing the social treatment practice towards the mentally disabled patients in a more human way. This model is followed by most of those respondents, who claim the necessity to adjust social practice and attitude toward mentally disabled patients;

- distancing from the mentally disabled ones. This model is followed by less than half of those respondents, who claim they need to adjust social practice and attitude toward mentally disabled patients;
- a change of verbally-behavioral practice to antisocial, hostile ones. This model is followed by a minority of respondents, 1.20%, respectively.

Future research will highlight the main features of social practice and attitude to people with intellectual disabilities, which differ in different societies. They all must have the right to receive special medical care and be mentally disabled. The process of distancing, the phenomenon of medical and social stigmatization, the provision of private psychiatric services, abuses committed by psychiatrists are also analyzed and reviewed.

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APPENDIX

Questionnaire

1. How do you feel about people with mental disorders?

A. These are the same people as the people with any other diagnosis.

B. These are people with more unpleasant diseases for themselves.

C. These are people with more unpleasant diseases than others.

D. These people are not sick, but simply with certain behavioral features

E. Your option:

2. Is it necessary to isolate mentally ill people from mentally healthy people?

A. Yes

B. No.

C. In some cases (specify in which ones)

3. In your opinion, is it permissible to replace a psychiatric diagnosis with a "less strict" one in the patient's best interests?

A. Yes

B. No.

C. Your option:

4. The most common attitude /behavior towards people suffering from mental disorders in society...

A. Hostile, hostile

B. The desire for destruction

C. Watchful, watchman

D. Avoidance

E. Neutral

F. Patronizing, caring

J. Friendly

K. Enthusiastic

L. Respectful

M. Worship

N. Your option

5. Is there a prejudice against the mentally disabled ones in modern society?

A. Yes

B. No.

C. Your option:

6. If a person with a mental disorder, being a patient from your hospital, does not want to take the recommended medicine by a psychiatrist, despite persuasion and arguments, what advice would you give to relatives?

A. Secretly add drugs to food

B. Force to take drugs by force

C. Hospitalize (including forcibly in court)

D. Execute outpatient involuntary treatment (through the court)

E. Treat with what he likes best - herbs, healers, etc. (use alternative medicine)

F. Leave him alone, let him not be treated

G. Your option:

7. Society for the Mentally Disabled...

A. Abuses its demands on them

B. Requires its patients as much as necessary

C. Less demanding than it should be

D. Your option

8. What role do people with mental illness play in society?

A. They are a burden

B. They are a generator of ideas for progress because they themselves and their fantasies give impetus to the activities of others

C. They are a significant factor influencing history, culture, and science because they are more common great people, geniuses, etc.

D. They are the leaders of the words of higher powers. Many of them have some gift: they can predict the future, heal, etc.

E. They are the object / the way of benefiting others (economic, political, psychological, etc.)

F. Your option

9. Mental disorder is:

A. The same diseases as any other

B. Mental illness does not exist; it is only the differences of some people from the same mass of others, conditionally declared pathology

C. The result of the influence of mysterious forces (gods, spirits, divination, corruption, etc.)

D. The result of the global control mechanism of human civilization in general biological and environmental contexts

E. Your option:

10. Most of the healthy people behave themselves to the mentally ill people:

A. As equals

B. As for the weak, those who can be commanded, despised

C. As for the weaker, but those who need to be protected, who need to be taken care of

D. As for the more powerful, meaningful, those who need to be listened to, whose requirements need to be met

E. As an obstacle to those who need to get rid of

F. Your option:

11. People with mental illness in society should behave ...

A. More restrained than healthy ones (including not to give a reason for hospitalization)

B. In behavior, they are allowed more liberties than healthy ones (their disease justifies everything)

C. The boundaries in their behavior are the same as among healthy people. So there is no difference

D. Your option

12. A patient with a mental disorder ignores the rules of coexistence (refuses to wash the floor, wipe the dust, returns home late, etc.), this ...

A. a sign of exacerbation of mental disorder, you need to increase the dose of drugs or hospitalize

B. a sign is when there is no reason to increase the dose of drugs or hospitalization

C. is not a sign of mental illness

D. Your option

13. Answering the questionnaire, what mental disorders did you most often mean:

A. personality disorders

B. neurosis

C. endogenous diseases (including schizophrenia)

D. organic diseases (including mental retardation)

E. all

F. did not think

G. your option:

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