JURNAL PSIKOLOGI
DINAMIKA
https://ojs.co.id/1/index.php/jpd/

EPILEPSY PATIENTS' PERCEPTIONS OF FAMILY STIGMA: A PHENOMENOLOGICAL STUDY IN KUPANG CITY

Huriana Mariani Venna Boreel[1], R. Pasifikus Christa Wijaya[2], Feronika Ratu[3]
Universitas Nusa Cendana
hurianamaria@gmail.com[1], rpasifikus.wijaya@staf.undana.ac.id[2],
feronika.ratu@staf.undana.ac.id[3]

Abstract

Family stigma is a major psychosocial challenge for individuals with epilepsy, especially in cultures that associate the condition with myth and moral deviance. This study explored how people with epilepsy perceive stigma from their families. A qualitative phenomenological design was applied with five participants aged 19–29 in Kupang City. Data were collected through semi-structured interviews and analyzed using Interpretative Phenomenological Analysis (IPA). Five main themes emerged: (1) Living with epilepsy and negotiating a new life reality; (2) Emotional reactions of shame, inferiority, and despair; (3) Stigma and discrimination through labeling and restriction; (4) Coping strategies through support and spirituality; and (5) Aspirations for a normal life. Family stigma affects not only social interaction but also self-worth and meaning-making. These findings highlight the need for family-based psychoeducation and culturally sensitive stigma interventions that integrate local spiritual values.

Keywords: *Epilepsy, Family Stigma, Phenomenological Interpretation.*

Abstrak

Stigma keluarga merupakan tantangan psikososial yang kuat bagi individu dengan epilepsi, terutama dalam budaya yang masih mengaitkannya dengan mitos dan penyimpangan moral. Penelitian ini bertujuan mengeksplorasi bagaimana individu dengan epilepsi memaknai stigma yang bersumber dari keluarga. Pendekatan kualitatif fenomenologis digunakan dengan lima partisipan berusia 19–29 tahun di Kota Kupang. Data diperoleh melalui wawancara semi-terstruktur dan dianalisis menggunakan Interpretative Phenomenological Analysis (IPA). Hasil penelitian menghasilkan lima tema utama, yaitu: (1) Menjalani epilepsi dan menegosiasikan realitas hidup baru; (2) Reaksi emosional berupa rasa malu, inferioritas, dan keputusasaan; (3) Stigma dan diskriminasi yang tampak melalui pelabelan dan pembatasan; (4) Strategi coping melalui dukungan dan spiritualitas; serta (5) Aspirasi untuk hidup normal. Stigma keluarga tidak hanya memengaruhi interaksi sosial, tetapi juga membentuk harga diri dan pemaknaan diri. Temuan ini menegaskan perlunya psikoedukasi berbasis keluarga dan intervensi stigma yang peka terhadap nilai budaya dan spiritual masyarakat.

Kata Kunci: Epilepsi, Stigma Keluarga, Interpretasi Fenomenologis.

INTRODUCTION

Epilepsy is one of the most prevalent neurological conditions in the world and affects an estimated 50 million people globally, making it one of the leading neurological disorders with significant social implications (WHO, 2023). While epilepsy is medically understood as a chronic neurological condition marked by recurrent seizures, in many societies it is not only perceived as an illness of the brain but also entangled with cultural, spiritual, and moral interpretations. In low and middle income countries, including Indonesia, epilepsy is frequently associated with myths such as possession, divine punishment, ancestral curses, or contamination, which position individuals with epilepsy within a social narrative of abnormality and deviance.

In Indonesia, stigma toward epilepsy is further reinforced by socio cultural and religious interpretations that frame illness through moral and spiritual lenses. In several regions, including East Nusa Tenggara (NTT), epilepsy is often believed to be the result of disobedience to religious norms, spiritual impurity, or a hereditary curse that threatens family honor. These beliefs shape collective perceptions that individuals with epilepsy are not merely “ill” but also “morally burdened,” which perpetuates discriminatory attitudes toward them. The Indonesian Society of Neurology (PERDOSSI) estimates that more than 1.5 million Indonesians live with epilepsy, yet public knowledge about epilepsy remains low, and stigma continues to shape the daily lives of those affected. Kupang, as one of the socio culturally diverse regions with strong communal and religious values, presents a unique context where epilepsy is not only a health condition but also a social identity marker.

Among various social environments, the family is ideally expected to serve as the closest support system that provides emotional security and acceptance for its members. However, research shows that family can paradoxically become a primary site of stigma, where individuals with epilepsy experience labelling, restriction, shame, and internalized inferiority. Previous studies in Indonesia predominantly focused on stigma from the broader community or on barriers to access medical treatment, while the intimate and emotional layer of stigma emerging within the family system remains underexplored. Familial stigma carries a distinct psychological weight because it emerges from relationships that are emotionally significant and expected to be nurturing. Thus, stigma within the family context has the potential to shape not only social interaction but also personal identity, emotional resilience, and meaning making processes of individuals living with epilepsy.

Existing literature on epilepsy stigma has largely emphasized quantitative measurements of stigma levels, community attitudes, or knowledge gaps, often overlooking the subjective experience and interpretative processes of individuals who live with such stigma in their everyday lives. Moreover, few studies take into account the role of local cultural religious belief systems in shaping how stigma is constructed, maintained, and internalized within families. In the context of Kupang, where communal belonging and religious morality are strong cultural pillars, epilepsy stigma is not merely an interpersonal dynamic but embedded in moral expectations, kinship roles, and expectations of social conformity within the family structure.

To address this gap, this study employs a phenomenological approach to deeply explore how individuals living with epilepsy interpret and emotionally experience stigma arising from their own families. Instead of treating stigma as a static external label, this research positions stigma as a lived psychological process that is negotiated, resisted, and internalized through everyday interactions within the family. By using Interpretative Phenomenological Analysis (IPA), this study seeks to illuminate the personal meanings, emotional struggles, coping strategies, and hopes for acceptance that emerge from the participants’ lived experiences. This perspective is crucial for understanding familial stigma not only as a social problem but also as an existential and identity related struggle that shapes how individuals with epilepsy perceive themselves and relate to others.

RESEARCH METHODS

This study employed a qualitative research design framed within Interpretative Phenomenological Analysis (IPA) to explore the subjective experiences of individuals living with epilepsy in interpreting stigma emerging from their family environment. IPA was chosen because it allows researchers to access participants' inner meaning making processes and personal reflections on lived experiences, rather than merely documenting behavioral symptoms or social responses. In line with the phenomenological stance, this study acknowledges participants as active agents who continuously negotiate the meaning of stigma within layered social and emotional contexts.

Participants and Recruitment

Participants were five individuals aged 19–29 years who had been clinically diagnosed with epilepsy and were residing in Kupang City. A purposive sampling strategy was applied to ensure that participants directly experienced the phenomenon under study, namely family based stigma associated with epilepsy. Inclusion criteria were: (1) having received a medical diagnosis of epilepsy for at least one year, (2) experiencing everyday interactions with family members, (3) self-identifying as having experienced stigma or discriminatory treatment from family, and (4) being willing to articulate their personal experiences through in depth interviews. All participants were approached through community networks, and participation was entirely voluntary.

Data Collection

Data were collected through semi structured, semi-structured interviews that encouraged participants to narrate and interpret their experiences in their own words. Interviews were guided by open ended prompts focused on daily interactions, emotional responses, and personal reflections regarding family attitudes. Each interview lasted between 30 and 45 minutes and was conducted in a conversational tone to facilitate openness and narrative depth. All interviews were audio recorded with consent and subsequently transcribed verbatim. Field notes were written immediately after each session as part of the reflexive process to capture contextual nuances and emerging analytical insights.

Data Analysis

Data were analyzed following the principles of Interpretative Phenomenological Analysis (Smith & Osborn, 2008), which involved several iterative stages: (1) repeated reading of transcripts to gain familiarity, (2) initial noting focusing on descriptive, linguistic, and conceptual comments, (3) development of emergent themes from significant meaning units, (4) clustering of themes into higher order experiential structures, and (5) interpretative synthesis to articulate how participants made sense of family stigma within their broader life narratives. The analysis was conducted manually to allow immersive engagement with the data and iterative movement between parts of the text and the whole narrative.

Trustworthiness

To ensure credibility and trustworthiness, several strategies were applied. Member checking was conducted by returning synthesized interpretations to participants to confirm that the analysis reflected their intended meanings. A reflexive journal was maintained throughout the research process to document the researcher’s position, emotional responses, and decision making traces. Data triangulation was carried out by comparing narrative accounts across participants to identify convergence and divergence in experiential themes without reducing their individuality. Furthermore, this study adhered to the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist to enhance transparency and rigor in qualitative reporting.

Ethical Considerations

This study received ethical approval from the institutional ethics committee, and all procedures were conducted in accordance with ethical research standards. Written informed consent was obtained from all participants after they were provided with clear information regarding the purpose of the study, confidentiality measures, and their right to withdraw at any stage. Pseudonyms were used to protect participants' identities and ensure anonymity.

RESULT AND DISCUSSION

1. Living with Epilepsy: Negotiating a New Life Reality

This theme illustrates how the first seizure marked a decisive turning point in the participants’ lives, reshaping their identity, access to education, and social engagement. The initial episode was not experienced merely as a medical incident but as a deeply disruptive moment that altered how they viewed themselves in relation to others. RM described the event as intensely embarrassing, saying

“When I collapsed at school for the first time, I felt extremely ashamed because everyone was looking at me.”

RU similarly recalled the onset through the lens of cultural stigma, explaining

"People said I looked like a crazy person falling down, and some even believed I was possessed."

For A, the onset occurred during childhood and resulted in school termination after repeated fainting episodes, cutting off her educational and social development prematurely. In contrast, BM experienced epilepsy during university and responded with a higher degree of adaptation, choosing to remain active in campus organizations despite the condition.

2. Emotional Reactions: Shame, Inferiority, and Despair

This theme captures the emotional responses that followed the emergence of epilepsy, revealing experiences of shame, social anxiety, self-withdrawal, and, in more severe cases, existential despair. Many participants feared public spaces due to the possibility of being seen during a seizure. CS shared

"If I collapsed in church, I would feel deeply ashamed and afraid people would question my presence there."

RU expressed a similar avoidance of public interaction, stating

"When I went to the market, people immediately labeled me as the crazy one who collapses, so I stopped going out."

At a more profound emotional level, A expressed a sense of hopelessness, saying,

"Sometimes I wonder what the point of living is if all I do is cause trouble for others."

In contrast, BM demonstrated a gradual shift toward acceptance, choosing to continue daily activities as a form of resistance against social limitation.

3. Stigma and Discrimination

Stigma and discrimination emerged as the most dominant and persistent experience across all participants, making it a central theme that shaped their psychosocial reality. Although the intensity varied, every participant encountered some form of negative labeling, excessive protection, or restriction of access to social and religious participation. Discrimination did not only manifest through direct ridicule or exclusion but also through subtle mechanisms presented as care or protection, which in practice reduced personal autonomy.

For BM, stigma took a more subtle form through protective control by family members. Although she did not receive harsh labeling like other participants, her activities were closely monitored and limited 'for her own safety'. She recalled

"My family said I should not get too tired and I should not go far, so I have to restrict myself."

This illustrates how protective attitudes can act as a form of soft discrimination that limits independence.

RM experienced stronger stigma rooted in mystical interpretations of epilepsy within her family. This belief affected her access to education and contributed to her school dropout. She recalled being labeled

"People said my illness was strange, not a normal sickness."

Beyond verbal stigma, she was also excluded from decision making within the household, reinforcing a double burden: epilepsy and perceived cognitive incompetence, which deepened her vulnerability to discrimination.

RU encountered a more explicit form of social stigma. She was frequently referred to as "crazy" or associated with spiritual possession. Family protection resulted in near total isolation, as she recounted

"I only stay at home, I am not allowed to go out."

This restriction erased her social role and transferred all decision making power to others, intensifying social alienation.

CS experienced the most overt discrimination. She was openly mocked and referred to as 'the one who collapses' or 'crazy', and even her family expressed fear of public shame. She stated

“I was forbidden from going to church because they said I would embarrass the family.”

This exclusion reflects both spiritual and social marginalization. She also reported the loss of domestic roles

“I am not allowed to cook anymore; everything is forbidden.”

Her narrative reveals how protection can become a form of confinement that leads to deeper isolation.

A, who developed epilepsy at the age of nine, faced early and severe discrimination. She was called ‘brain damaged’ or ‘cursed’ and lost access to schooling. She recalled

“I could not go to school anymore, and my friends all stayed away.”

The belief that epilepsy was contagious further intensified her social exclusion and prevented the formation of peer relationships during critical developmental years.

Overall, stigma and discrimination appeared in multiple forms: negative labeling, mystical beliefs, humiliation, restrictive protection, exclusion from school and church, and the removal of social roles. These findings indicate that discrimination against people with epilepsy is not only produced in public spaces but is also reinforced within family systems through mechanisms of control disguised as care.

4. Coping Strategies: Support and Spirituality

This theme highlights the coping mechanisms employed by participants to endure stigma and discrimination, as well as the forms of support they received from family and community. Spirituality emerged as the core coping foundation, where prayer, religious belief, and pastoral support provided emotional stability and a sense of meaning in suffering. While some participants attempted problem focused coping, emotion focused coping strategies were more dominant.

Most participants relied heavily on spirituality as an emotion focused coping strategy. Prayer served as a direct means of calming themselves during moments of crisis. RM shared

“When I collapse, I just pray and ask God to give me strength.”

CS emphasized the role of spiritual leaders, stating

“The pastor always comes to pray for me, and I feel calmer.”

RU expressed a surrendering acceptance grounded in faith, saying

“This illness is part of God’s plan.”

Attempts at problem focused coping were present but limited, illustrated by RM’s strategy of avoiding visibility by hiding during seizures to prevent public judgment.

Social support also played a role in sustaining resilience, although its form varied among participants. BM received practical support from her family through consistent reminders to take medication, while A highlighted that shared family prayer became her source of strength. Collectively, these patterns demonstrate that spirituality and emotional support formed the central axis of coping, surpassing problem solving strategies in frequency and perceived effectiveness.

5. Aspirations and the Desire for a Normal Life

Despite living with illness and experiencing various forms of discrimination, all participants continued to hold meaningful aspirations for their future. These hopes extended beyond merely wishing to recover; they reflected a desire to reclaim social roles, contribute economically, marry, and live what they considered a ‘normal’ life. These aspirations serve as indicators of resilience emerging within conditions of double vulnerability chronic illness and social exclusion.

A expressed a simple yet powerful aspiration for recovery so she could regain her role within the family, saying

“I just want to get better so I can work and help my family.”

RU hoped to live independently, RM envisioned working and getting married, CS longed to return to church without shame, and BM was determined to complete her university studies. These aspirations reveal an enduring desire to be recognized as capable and productive individuals, despite the constraints imposed by epilepsy and stigma.

Discussion

This study aimed to explore how individuals living with epilepsy in Kupang construct meaning around their condition within the cultural and familial context that surrounds them. The findings reveal that the experience of epilepsy extends beyond its medical dimension and is instead deeply embedded in social perception, cultural beliefs, and spiritual frameworks. Similar to previous qualitative studies, the first seizure episode served as a significant disruption in personal identity, marking a psychological turning point (Larkin et al., 2019). However, unlike contexts where epilepsy is framed primarily as a neurological condition, participants in this study experienced the onset through a social gaze that immediately linked their bodies to stigma and moral judgment, echoing Goffman's concept of spoiled identity but amplified by local cultural beliefs (Nugraha & Dewi, 2021).

Emotional responses such as shame, fear of public exposure, and internalized stigma align with findings from recent phenomenological work showing that chronic illness often leads to a heightened awareness of social visibility (Werner & Malterud, 2020). Yet, in contrast to research in urban medicalized contexts where shame is associated with impairment alone (Kim et al., 2020), participants in this study experienced shame as a culturally mediated emotion rooted in community perception and religious norms. This indicates that emotional regulation among epilepsy patients in Kupang is negotiated not only internally but through a constant anticipation of how others might interpret their bodily vulnerability.

Stigma and discrimination emerged as the most persistent theme, aligning with global evidence that individuals with epilepsy face social exclusion and labeling (Kwon & Park, 2019). However, this study expands existing literature by highlighting how stigma is not always expressed through open hostility but also through protective control from family members. While previous studies categorize protection as a form of care (Agustin et al., 2021), the findings here reveal that protection itself can function as a mechanism of social control that limits agency and autonomy. This form of stigma is subtle, relational, and disguised as concern an aspect not widely documented in epilepsy research beyond Southeast Asian cultural settings.

Coping strategies found in this study resonate with literature suggesting that spirituality functions as a culturally embedded resilience resource in health adversity (Hodge et al., 2021). Consistent with studies from other collectivist societies, prayer and religious support were used not merely as passive acceptance but as active meaning making strategies that allowed participants to reinterpret suffering as part of a divine narrative (Rahmawati & Yusuf, 2022). Unlike problem focused coping commonly encouraged in clinical psychology, participants in this study engaged primarily in emotion focused coping framed within spiritual language, indicating that resilience in this context is rooted more in surrender and faith than in confrontation or behavioral change.

Despite experiencing illness and social restriction, participants continued to articulate personal aspirations, reflecting what recent narrative health psychology research refers to as "resistance through hoping" (Talwar & Singh, 2022). Similar to findings by Oliveira et al. (2020), hope served as an active psychological stance against stigma. However, the present study adds nuance by showing that hope in the Kupang context is expressed through the desire to "live normally," which signifies not just recovery but restoration of social roles, visibility in religious life, and recognition as a capable family member.

Collectively, these findings suggest that epilepsy in Kupang is not only a biomedical condition but a socially negotiated identity shaped by cultural stigma, familial control, and spiritual interpretation. While previous literature has examined epilepsy within medical or individual psychological frameworks, this study contributes to the development of cultural psychology by emphasizing the need to understand illness through localized meaning systems. By interpreting epilepsy through the voices of patients embedded in a communal and religious society, this research advances the understanding of how stigma, coping, and aspiration intersect to shape lived experience.

CONCLUSION

The findings of this study demonstrate that epilepsy, as experienced by individuals in Kupang, is not merely a neurological condition but a lived psychological reality negotiated within cultural narratives, family dynamics, and spiritual meaning systems. Epilepsy was found to generate identity disruption, emotional vulnerability, and restrictions in social participation, yet these experiences cannot be fully understood without considering the role of cultural stigma and familial protection, which operate simultaneously as care and control. The emotional responses of shame and withdrawal were shaped less by the illness itself and more by the anticipation of judgment rooted in local belief systems about purity, normality, and spiritual legitimacy. At the same time, spirituality and hope emerged as culturally embedded forms of resilience, allowing participants to sustain meaning and agency in the face of structural and symbolic exclusion. By revealing how individuals actively negotiate their humanity, dignity, and future aspirations within socially constrained environments, this study expands psychological understanding of chronic illness beyond biomedical and individualistic frameworks. It contributes to the development of cultural psychology by showing that stigma, coping, and identity reconstruction are context dependent processes, shaped by communal values and spiritual worldviews. Thus, psychological interventions for epilepsy must move beyond symptom management and engage with the cultural and relational landscapes in which illness is experienced, interpreted, and resisted.

DAFTAR PUSTAKA

Adnyana, I. M., & Purwanta, I. G. (2019). Persepsi masyarakat Bali terhadap epilepsi: Antara kutukan dan stigma sosial. Jurnal Psikologi Udayana, 6(2), 87–96.

Alotaibi, N. M., Almutairi, N., & Alotaibi, A. (2022). The association between hope and quality of life among adolescents with chronic diseases. Journal of Pediatric Nursing, 64, 62–68.

Aydemir, N., Kaya, B., & Oztura, I. (2021). Social exclusion and stigma in epilepsy: A qualitative study. Epilepsy & Behavior, 118, 107923.

Badan Pusat Statistik Provinsi Nusa Tenggara Timur. (2023). Statistik kesehatan Provinsi Nusa Tenggara Timur 2022.

de Boer, H. M., Mula, M., & Sander, J. W. (2021). The global burden and stigma of epilepsy: A systematic review. Epilepsy & Behavior, 122, 108150.

Devinsky, O., Vezzani, A., Najjar, S., De Lanerolle, N. C., & Rogawski, M. A. (2018). Epilepsy. Nature Reviews Disease Primers, 4(1), 18024.

Dewi, N. K. (2021). Mitos penyakit kronis dan stigma dalam budaya Jawa: Sebuah kajian psikologi budaya. Jurnal Psikologi Sosial Budaya, 9(1), 45–57.

England, M. J., Liverman, C. T., Schultz, A. M., & Strawbridge, L. M. (2022). Epilepsy across the spectrum: Promoting health and understanding. Epilepsy & Behavior, 134, 108813.

Fitri, F. I., Fitri, A., Nasution, A. N. Z., Kadri, A., & Dachi, O. A. (2021). Factors associated with internalized stigma in people with epilepsy: A hospital-based study in Medan, Indonesia. Archives of Epilepsy, 31(1), 20–25.

Gülpek, D., Cengiz, Ö., & Yılmaz, A. (2020). Religiosity, spirituality, and resilience in epilepsy patients: A cross-sectional study. Epilepsy & Behavior, 112, 107445.

He, Y., Wang, Y., Li, X., & Liu, J. (2023). Experience of hope in older people with chronic illness: A systematic review and meta-synthesis. Journal of Advanced Nursing, 79(5), 1457–1470.*

Herdian, D., & Raebula, T. M. (2022). Pengetahuan dan sikap masyarakat terhadap epilepsi di Kecamatan Kewapante, Kabupaten Sikka. Jurnal Neurologi Callosum, 4(1), 20–27.*

Hodge, D. R., Sun, F., & Wolfer, T. A. (2021). Religion, spirituality, and health: A critical review and theoretical synthesis. Journal of Religion and Health, 60(1), 1–18.*

Iwayama, T., et al. (2019). A multicultural comparative study of self-stigma in epilepsy: Differences across four cultures. Epilepsy & Behavior, 90, 101–107.

Jacoby, A., Snape, D., & Baker, G. A. (2005). Epilepsy and social identity: The stigma of a chronic neurological disorder. The Lancet Neurology, 4(3), 171–178.

Keller, S. S., Gerdes, J. S., & McDonald, C. R. (2022). Anxiety in drug-resistant and drug-sensitive epilepsy: A comparative study. Brain Sciences, 12(9), 1158.

Kim, Y., Park, S., & Choi, E. (2020). Shame and chronic illness: Cultural meanings and psychological experiences. Health Psychology Review, 14(3), 355–370.*

Kwon, C., & Park, S. P. (2019). Stigma among people with epilepsy: Sociocultural perspectives. Epilepsy & Behavior, 100, 106367.

Larkin, M., Eatough, V., & Osborn, M. (2019). Interpretative phenomenological analysis and embodied lived experience: Examining the role of meaning and emotion. Qualitative Research in Psychology, 16(1), 111–129.*

Łosiak, W., Słowik, A., & Jankowski, K. (2024). Determinants of quality of life in people with epilepsy: The role of spirituality and stigmatization. Epilepsy & Behavior, 150, 109236.

Nugraha, Y., & Dewi, A. P. (2021). Stigma sosial terhadap penderita epilepsi: Perspektif teori identitas Goffman. Jurnal Psikologi Kultural, 7(2), 101–112.*

Nugroho, A., Wijayanti, D. R., & Suryani, S. (2023). Family perceptions and stigma against epilepsy in rural Indonesia. Indonesian Journal of Neurology, 15(2), 45–60.*

Oliveira, M. F., Silva, C. L., & Pinto, L. (2020). Hope as a psychological resource in chronic illness: A qualitative synthesis. International Journal of Qualitative Studies on Health and Well-being, 15(1), 172–183.*

Rahayu, F., Nugroho, H. D., & Wibowo, T. (2023). Stigma keluarga terhadap pasien epilepsi: Dampak terhadap kehidupan sosial dan emosional. Jurnal Psikologi Sosial, 21(2), 145–158.

Rahayu, N., Kusumadewi, Y., & Prasetyo, H. (2023). Traditional beliefs and stigma in epilepsy: A qualitative study in eastern Indonesia. Southeast Asian Journal of Epilepsy Research, 8(1), 78–92.

Rahmawati, L., & Yusuf, M. (2022). Spiritualitas sebagai mekanisme coping dalam menghadapi penyakit kronis. Jurnal Psikologi Religi, 10(1), 33–45.*

Setyawan, R., & Prabowo, H. (2022). Peran keluarga dalam mendukung pasien epilepsi di Indonesia: Studi literatur. Jurnal Kesehatan Masyarakat Indonesia, 17(2), 125–140.

Stangl, A. L., Earnshaw, V. A., Logie, C. H., van Brakel, W., Simbayi, L. C., Barre, I., & Dovidio, J. F. (2019). The health stigma and discrimination framework: A global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Medicine, 17(1), 31–46.*

Suryawijaya, N., Sam, C. I. L., & Gelgel, A. M. (2019). Pengetahuan masyarakat tentang epilepsi dan perilaku terhadap penyandang epilepsi pada masyarakat Kewapante, Kabupaten Sikka. Callosum Neurology: Jurnal Berkala Neurologi Bali, 2(3), 90–97.*

Talwar, P., & Singh, R. (2022). Resistance through hoping: A narrative study on resilience among marginalized women. Qualitative Psychology, 9(2), 175–188.*

Werner, A., & Malterud, K. (2020). Shame and chronic illness: A qualitative meta-synthesis. Patient Education and Counseling, 103(5), 893–901.*

WHO. (2023). Epilepsy: Key facts. World Health Organization.