LUPINE PUBLISHERS

Online Journal of Neurology and Brain Disorders

DOI: 10.32474/OJNBD.2021.05.000209

ISSN: 2637-6628

Review Article

Stigmatization and Psychiatry: A Local Review

Saeed Shoja Shafti*

Full Professor of Psychiatry, University of Social Welfare and Rehabilitation Sciences (USWR), Razi Psychiatric Hospital, Iran

***Corresponding author:** Saeed Shoja Shafti, Full Professor of Psychiatry, University of Social Welfare and Rehabilitation Sciences (USWR), Razi Psychiatric Hospital, Iran

Received: February 08, 2021 **Published:** February 22, 2021

Summary

Stigmatizing attitudes toward persons with mental syndromes are prevalent in the general population and even among mental health professionals, a problem that may result easily in public avoidance, constant discrimination, and declined help-seeking behavior. The effect of stigma is twofold: Public stigma is the response that the public has to people with mental disorder. Self-stigma is the bigotry which persons with mental disorder turn against themselves. The WHO has advised that stigma is one of the largest barricades to treatment engagement, even if management is operative, even in low-income nations. While before and according to a series of researches the outcome of severe mental illness is generally better in developing societies than in developed countries, and it has been suggested that stigma is less severe or non-existent in unindustrialized nations, the current studies and observations do not confirm such an optimistic hint and the idea that stigma attached to mental illness is a global phenomenon seems a reasonable inference. In the present article, the issue of stigmatization, deinstitutionalization, national goal setting, and real situation of various modules of psychiatric rehabilitation, in the context of social or public psychiatry, especially in developing countries, is discussed, from a practical point of view.

Keywords: Chronic Mental Patient; Severe Mental Illness; Psychiatric Rehabilitation; Public Psychiatry; Social Psychiatry; Stigma

Introduction

A mental illness is a "clinically substantial psychological or behavioral ailment that happens in an individual and that is concomitant with existing distress or debility or with an importantly amplified risk of suffering pain, death, incapacity, or an imperative loss of freedom," which results from the expression of a psychological, behavioral, or biotic dysfunction in the person [1]. Stigmatizing attitudes toward persons with mental syndromes are prevalent in the population and even among mental health experts. Unlike people with physical disabilities, those with mental conditions are often observed by the public to be in control of their debilities and accountable for causing them [2]. The effect of stigma is twofold: Public stigma is the response that the general public has to individuals with mental disorder. Self-stigma is the bigotry which persons with mental disorder turn against themselves. Both public and self-stigma may be assumed in terms of three elements: stereotypes, prejudice, and discrimination [3]. The WHO has advised that stigma is one of the largest barricades to treatment engagement, even if management is operative, even in low-income nations [4]. Stigmatization of people with mental disorders may result in public evading, steady discrimination, and declined help-seeking behavior. In a survey in north America, more than one half of the respondents reported that they were reluctant to spend an evening socializing with, work next to, or have a family member marry a person with mental illness. Shame is reported as one of the main obstacles from seeking help for mental disorders in both developing and developed societies [5]. As a result, stigma is as a possible key reason in mental health services access and use, particularly under-utilization of obtainable facilities by some segments of society, most markedly minority racial/ethnic groups [6]. Goffman believed that stigma is an actual/inferred attribute that damages the bearer's reputation and degrades him/her to a socially discredited situation. Hence, social devaluation and rejection are customary experiences of the stigmatized. Affiliation with the stigmatized, as well, causes a secondary stigma – courtesy stigma [7]. Nonetheless, modified labeling theory, identifies the socio-cultural framework of stigma, a societal paradigm that reflects relationships of power working at

social levels [8]. In revised labeling theory, dominant individuals in society inflict stereotypically destructive labels on those they presume undesirable, whom they later devaluate and victimize [9]. This conceptualization of stigma parallels with a social psychology perspective that stigmatization is related with human cognizance through stereotyping and bigotries [10]. For instance, some studies have detected that clinicians exhibit 'unintentional biases' in their decision and responses to patients and their relatives, in spite of sincere commitments to providing patient-centered and culturally sensitive care [11]. Self-stigma theory further postulates that some, among the socially devalued and discriminated patients, internalize public stigma by underestimating themselves and unsuitably changing their behavior and approaches [12]. The institutional context for the stigmatization of consumer has also been explored in a number of studies. Most institutional stigma research has focused on service providers, i.e., psychiatric and primary physicians, psychologists, other healthcare professionals - as stigmatizes, rather than the institutions themselves as stigmatizes [13]. In spite of the high incidence of these circumstances, known managements have shown helpfulness in amending the problem and enhancement of personal functioning in society [14]. Based on Goffman's preliminary definition [15], Jones and colleagues [16], as well, recognized six proportions of stigma. These consist of conceal-ability, disruptiveness, course, origin, aesthetics, and peril [17]. Moreover, Corrigan and other scholars [18,19] recognized dimensions of controllability, pity, and stability. It is significant to comprehend that these scopes can either present individually or concurrently to create stigma [17].

Background

Far more than any other kind of sickness, mental diseases are subject to undesirable judgments and stigmatization [20]. Many patients not only have to cope with the often-distressing properties of their illness, but likewise undergo social refusal and prejudices. Stigmatization of the psychiatric patients has a long history, and the term "stigmatization" itself shows the adverse implications. in antique Greece, a "stigma" was a marque to spot slaves or prisoners [21]. For centuries, society did not treat people suffering from schizophrenia, autism, depression, and other mental ailments better than criminals or slaves; they were trapped, executed or tortured. All through the Middle Ages, mental illness was supposed as a penalty from Deity: victims were thought to be haunted by the evil soul and were burned, or thrown in madhouse and jail, where they were chained to their beds or the walls. Thru the Enlightenment, the mental patients were finally freed from their institutions and chains [21]. Nevertheless, stigmatization of mental ailment is still a core communal problem. The masses are customarily oblivious concerning this problem, and fear of the mentally ill remains universal. Essential discrimination of mental patients is still ubiquitous, whether in administration or in recovery efforts. On the other hand, stigma can be acknowledged on three theoretical levels: behavioral, emotional and cognitive, which allows us to detach mere stereotypes from discrimination and preconception. Stereotypes refer to man-made opinions and attitudes towards members of certain groups, such as racial or sacred groups, as well as the psychologically ill. The most noticeable stereotypes surrounding the mental ill patients presume dangerousness, unreliability and unpredictability; patients suffering from schizophrenia are most affected by such viewpoints [21]. A logical idea regarding the stigma of mental illness was first developed in the middle of the 20th century, first theoretically and lastly empirically in the 1970s.

The book "Stigma: Notes on the Management of Spoiled Identity", published in 1963 by the American sociologist Erwin Goffman, which laid the basis for study of stigma as a methodical discipline and defined how stigmatized individuals deal with the problem [21]. In this regard, Goffman was a bit critical of mental hospices because, according to him, these further could increase stigmata rather than empowering patients to lead ordinary lives. This was consistent with many of his existing scientists, including Michel Foucault, Ronald Laing and Thomas Szasz, who believed that the denouncing outcomes of mental illness could be ascribed to how psychiatry was organized and not to the mental syndrome itself [21]. Essentially, the stigma of mental disorder is ever-present. There is no culture, society or country, where persons with mental complaint have the same mutual worth as individuals without a psychological condition [22]. On the other hand, though stigma is pervasive, the experience of the stigmatized patient is influenced by communal culture. For instance, the role of magical, religious or supernatural justifications of mental illness still succeeds in several non-Western civilizations. Moreover, there are dissimilarities in stigmatization depending on the nature of complaint [23-25]. In a Swedish study on families of individuals with psychiatric sicknesses, an extensive number of cases showed that the sick kin would be better off deceased and/or demanded that the patient and the family member had never encountered or that the patient had under no circumstances been born [26]. Then again, proposing biological causes for these conditions might have harmful effects in terms of approval and integration of the mental patient [21]. So far, psychiatric stigma is a severe social problem, as well as a heavy burden for affected persons [27,28]. Actually, although the technical writings showed that persons commonly see those with mental illness as dangerous [29], methodical works have established that an important link between the most of psychiatric ailments and aggressive actions does not exist [30], and so approaches to people with mental disorder are in most cases associated to a prejudiced bias and/or stereotype [31,32]. Because the reason to which the mental disorder condition is ascribed (biogenetic vs. psycho-sociological) has been considered to be one of the leading issues underlying the stigmatizing routes [17], etiological theories have been utilized as a persuasive trigger to overwhelm stigma in several

public health platforms that have been proposed for reduction of discrimination toward psychiatric patients. In view of that, psychological illnesses should be observed as medical disorders that should be treated with medical managements, as like as all other sicknesses [33-35].

Contemporary DE-Stigmatization Strategies

Plans for addressing stigmatization of persons with mental syndromes can be divided into three groups: Protest, education, and contact. There are some proofs that protest against prejudiced descriptions of mental illness may be effective in decreasing stigmatizing conducts against individuals with mental illnesses. Information/education about mental illness may promote a better understanding of mental disorder, and educated people are less probable to support stigma and discrimination. Also, a reverse relationship between having contact with a person with mental illness and sanctioning stigmatizing demeanors has been acknowledged [5]. In addition, three channels are used to arbitrate these strategies: opinion leaders, persons of trust and mass media, [21]. On the other hand, family therapy, as well, may help families comprehend psychiatric illnesses and how they can help and/or support the troubled individual [36]. Some research recommends that more care to relatives of persons with mental illness is required [37]. Besides addressing communal views of mental condition, psychiatrists, as well, need to look at their own exercise because the mission of the psychiatrist is much more than constructing a diagnosis and delivery of a fitting sticker. People with psychological ailment need assistance in making sense of their competences. As in other divisions of medicine, suitable and acceptable managements need to be built on the grounds of good interactions in which patients feel caught and understood. Support and empathy are expected to increase a positive relationship, while retributive actions and insensible approaches will do the reverse [38, 39]. Anti-stigma intrusions should regularize the experience of psychological illness and target views that individuals with mental condition are hazardous. Such interferences can be combined with school-based core curriculum and target social groups (e.g., those with scarcer years of schooling) that continuously authorize undesirable attitudes as regards psychiatric patients [40]. Besides, it should emphasis on increasing encouraging individual interaction with psychiatric patients, target leading people, and should include messages about the customs in which stigma and discrimination encumbers life purposes and options [37]. In addition, interferences should be personalized to the assets, concerns, and social situation of a distinct group or milieu. Such modification may amplify the efficiency and relevancy of the said intercession. Furthermore, many, continuous interactions with people with emotional illness is fortified as numerous constructive contacts can more effectively reduce stigma than a solitary meeting [41]. Likewise, panic of the stigmatizing effects of treatment has waned by delivering care in less defaming settings like schools, community centers and primary care offices [42]. Alternatively, while anti-stigma interferences was on the premise that increased cognizance and acceptance of mental illness will lead to diminutions in stigma, amplified mental health data has been correlated occasionally with unscathed or even augmented levels of stigma [43].

Discussion

Stigmatization in psychiatry, while is abstractly similar to stigmatization due to chronic contagious diseases, like leprosy or tuberculosis, is practically different from it. It involves loss of function, loss of safety, and loss of ordinary social relations, which are not easily responsive to current drug treatments or standard therapeutic strategies. For example, while in leprosy, keeping social distance and treatment of the disease with available drugs can improve the personal function and feeling of safety in others in short-term, in schizophrenia, neither of the said deficiencies are retrievable acceptably even in long-term. On the other hand, there are some differences between stigmatization in the developed societies and developing countries. For example while stigmatization in developed societies can be established more rapidly or remarking, in developing or non-developed nations it may develop later or more blunted. But finally and in any case it will develop. No tribe or nation in the world can accept the erratic behavior of its fellow citizen, who has lost his or her insight regarding the actualities of real world and has turned into a burdensome individual that demands persistent unidirectional free care, food and shelter. In addition to said requirements, his or her dangerous behavior, as well, should be considered, which may jeopardize insistently the patient's or relatives' life and wellbeing. On the other hand, occasional or likely abusing of psychiatric labeling by some of mental patients for deliberate performance of crime, increase the subjective sense of unpredictability in this regard. Though many of positive symptoms or crazy conducts may decrease by means of reasonable treatments, the remaining deficit syndrome in schizophrenia, partial remission or recurrent relapses in mood disorders, drug non-compliance or treatment-refractoriness in both, suicidal or homicidal threats, uncontrollable aggression and irritability, inability to work or insecure employment, and failure to respond appropriately to financial or monetary necessities, can reinforce the stigmatization so inflexibly that no preaching or lecture can overcome that. Here, one of the major differences between developed societies and developing nations is traditional tolerance of misfortunes, which seems to be more inevitable in the later ones.

After invention of psychotropic drugs, especially chlorpromazine in the early1950s, establishment of community psychiatry with its wide-ranging goals, or better to say, rehabilitation of chronic mental patients, became conceivable. So, deinstitutionalization and discharge of severe and chronic mental patients in short-term

constituted the main purpose of modern public psychiatry. Facilities, like community mental health centers, with their multidisciplinary services, and related agenda, like establishing case management network, residential management, crisis intervention services, vocational rehabilitation, self-help groups or psychosocial clubs, assertive outreach, day hospitals, night hospitals, and associated psychosocial interventions, like behavioral family management, altogether intended to improve chronic mental patient's function and sociability, parallel to decline his or her vulnerability by pharmacotherapy. But such a philanthropic program could not be accomplished on a national scale without its own specific budget, staff, and settings. Also, it needs to be followed or executed incessantly, habitually and in all places, not scholastically or occasionally. Without such preparations, deinstitutionalization has no result except than upsurge of wandering, homelessness, delinquency, addiction, and familial chaos, which can be accounted as real threats against normal and functional part of society. Surely, basic and citizens' rights, as well, advocate functional and vocational rehabilitation of chronic mental patients up to a level approximately similar to pre-morbid situation, and turning helpless, unstable and unemployed patients into independent, working and reliable persons. But such compassionate goals, in short-term and long-term, are not reachable by incomplete maneuvers or facilities. While such a dilemma is not restricted to undeveloped nations, and is observable relatively in technologically advanced societies too, its shortage is more palpable in the unindustrialized civilizations. Even now, tactics like case management, behavioral family management, psycho-education, which does not demand specific financial plan or amenities, except than devoted labor force, do not have a full and distinct role in rehabilitative packages, and above all, still the concepts of rehabilitation and independency have not been well-defined nationally and practically. Case management, which is a vital opening factor in community psychiatry, has not found its prearrangement and enthusiasts, whether pedagogically or executively, and has yet an unsettled role. Social skills training, whether in the frame of basic training, or modules or attention - focusing procedure, for self-management of areas like medication, home finding and maintenance, recreation and leisure skills, budget management, usage of public agencies, training and enhancement of interactional, communicative and conversational skills, in family and social areas, and finally problem solving skills, has not been considered systematically as a core part of preliminary psychosocial rehabilitation. Crisis intervention services, like telephone support, home support, community home support or crisis lodging, in many places or occasions, does not have a schematic plan. Housing of chronic psychiatric patients after release from hospital, which is a very important part of the rehabilitation, and consists of locations like half-way houses, group houses, supervised or satellite apartments are not accessible, even in large cities or urban areas.

Vocational rehabilitation, with its basic elements like work skills assessment, work adjustment, job skills training, sheltered employment, transitional employment, job finding and job maintenance, which is a key element designed for making self-governing and working people, is usually doable partially and recreationally, not completely and enthusiastically [44]. Why the situation is so after several decades of official commencement of psychiatric rehabilitation in developed societies? Why in many of the developing countries it is still in the pilot phase of assessment, or maybe in complete ignorance? Why deinstitutionalization program has not been successful enough, in spite of evolution of psychotropic medications? Two studies of WHO have found that the outcome of schizophrenia was generally better in developing societies than in developed countries, which was associated by the setting; acute onset; being married or cohabiting with a partner; and having access to a supportive network [45]. Similar findings about better outcomes of schizophrenia in developing countries were found by other investigators, too [46, 47]. So, while it is suggested that stigma may be less severe in developing countries [45-49], a study carried out in India, in which 463 persons with schizophrenia and 651 family members were interviewed in four cities, reported that two thirds of the respondents had suffered discrimination [5]. In Ethiopia, also, among relatives of people with a diagnosis of schizophrenia or mood disorders, 75% reported that they had experienced stigma due to the presence of mental illness in the family, and 37% wanted to conceal the fact that a relative was ill [5]. In a large survey carried out in China, too, among people with schizophrenia and their relatives, 50% of the respondents reported they had felt significantly stigmatized [5]. Also, in a similar study in Iran, 45% of relatives of people with diagnosis of schizophrenia and 32.5% of relatives of depressive patients had experienced discrimination and humiliation and suffering from the stigmatization, which in turn had made them feel uncomfortable and ashamed [50]. So while the above proofs are not in harmony with the verdicts of Jablensky [46], Hopper et al. [47], Fabrega [48] and Ng [49], they challenge the conclusion of Dols, too, who believed that there is almost no stigmatization in Islamic societies [51].

So, the idea that stigma attached to mental illness is a global phenomenon seems a reasonable inference (22). Also, disregard to probable neglects or faults, since the "disturbance of function" due to clinical signs and symptoms constitutes the basis of psychiatric disorders and diagnoses in 'Diagnostic and Statistical Manual of mental disorders (DSM)' and 'International Statistical Classification of Diseases and Related Health Problems (ICD)', an actual fact which is always noticeable in clinical or social settings, critical standpoints of some of scholars regarding the likely role of psychiatric organizations and services in generation of stigmatization [21] do not seem to be an exact or working extrapolation. Higher acceptance

of psychiatric patients by associated relatives in developing societies, in comparison with the developed nations, does not signify heartfelt compliance of families towards wrongdoings of other members who suffer from severe mental illness, or guaranteeing patient's independency and good fortune. It is more comparable to the fact that misdemeanors of a crazy person have more echoes in complicated urban zones than in isolated rural regions. Families in developing societies usually tolerate or keep their ill relatives because, culturally, they see no alternative except than that. They cannot select other plans because their kindred and cultural values expect them to comply stereotypically with the existent scheme, even if it has detrimental outcomes. On the other hand, no national program can be achieved successfully when no social necessity or core insight demands that. Moreover, it is noticeable that incongruity between program, staff, setting and culture can undermine the end-result of every blueprint, disregard to its usefulness or principles. Then again, neoliberalism and privatization, as newfangled global economic policies, with their profit-seeking and progress-pursuing objectives, have challenged, intellectually and fiscally, the psychiatric rehabilitation, with its basically liberal purposes, which perceives economical independency of mental patient a primary objective and appreciates one-sided spending of money for the sake of rehabilitation a right, not charity.

So, there is a basic discrepancy between the said outlooks. Consequently, with respect to psychiatric rehabilitation, the resultant side effects of such a process in developing countries with more vulnerable economic foundations can be more confusing than advanced societies with more stable financial competencies. Also, integrating psychiatric wards into general hospitals, along with its unavoidable side effects and restrictions, reduction of public psychiatric beds and holding chronic mental patients in private sheltered sanatoriums, and turning psychiatric units into medical treatment centers, are generally in conflict with the philosophy of social psychiatry and deactivate strategic purposes of psychiatric rehabilitation. Such movements show that the deinstitutionalization has not been in cooperation with the psychiatric rehabilitation and has only been disguised according to the social necessities and circumstances. So, the roots of stigmatization in psychiatry, which has been stated before, have not been faded methodically and by way of rehabilitation in the last decades, and therefore expecting improvement of stigmatization could not be a faithful anticipation. Though psychotropic medications have paved the way for great optimisms, their attainment is not imaginable without systematic endeavors, investments and policy adjustments. Improving managerial rehearses by training of enthusiast apprentices in fellowship of public psychiatry, clarification of associated programs for political and administrative decision makers, for planning of necessary finances and beginning of multidisciplinary approaches, formulating necessary packages for measured amendment of cultural aspects of stigma, are among the key elements for solving the present problem. If peoples' distrust is due to patients' misbehavior, whether intentionally or unintentionally, then it is not correctable without acceptable behavioral recovery. In conclusion, considering the abovementioned background and outcomes of methodical studies, it seems that assessing stigma is a very complex issue. Indeed, it involves complex aspects, such as etiological beliefs, attitudes, prejudices, personal, and social problems, both toward mentally ill persons and in the mental disorders' perceiver, while taking into account the role of different cultures. Moreover, and of fundamental significance in this context is the distinction of different mental disorders, such as schizophrenia, depression, and addiction, which should be studied individually to highlight the specificity of their relations with stigma [52].

Conclusion

Due to a series of cultural, financial and administrative reasons, deinstitutionalization and psychiatric rehabilitation have not been taken place meticulously in developing countries in the last decades, and in consequence improvement of stigma has never been a conceivable or achievable goal. Achievement of such a valuable objective at a national level, demands a sequences of social, fiscal and executive amendments, which may not, as well, be an easy task in the current unstable situation of world. Nullifying the "disturbance of function" by means of psycho-pharmacotherapy and thorough psychosocial rehabilitation is the main key for modification of stigma.

References

1. (2000) American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th Edn.,). Washington, USA.
2. Douglas M (1994) The construction of the physician: a cultural approach to medical fashions. The healing bond: The patient practitioner relationship and therapeutic responsibility. London: Routledge.
3. Britten N (1994) Patients ideas about medicines a qualitative study in a general practice population. Br J Gen Pract 44(387):465-8.
4. Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, et al. (2007) Treatment and prevention of mental disorders in low-income and middle-income countries. Lancet 370(9591): 991-1005.
5. Maj M (2009) World Aspects of Psychiatry: Stigmatizing Attitudes Toward People with Mental Disorders. (9th Edn), Philadelphia: Lippincott Williams & Wilkins, 4516.
6. Mukolo A, Heflinger CA, Wallston KA (2010) The stigma of childhood mental disorders: A conceptual framework J Am Acad Child Adolesc Psychiatry 49(2): 92-103.
7. Goffman E (1963) Stigma Notes on the management of spoiled identity. Englewood Cliffs, NJ: Prentice Hall.
8. Link BG, Phelan JC (2001) Conceptualizing stigma. Annual Review of Sociology 27: 363-385.
9. Link BG, Cullen FT, Struening EL, Shrout PE, Dohrenwend BP (1989) A Modified labeling theory approach to mental disorders: an empirical assessment. American Sociological Review 54(3): 400-423.
10. Heatherton TF, Kleck RE, Hebl MR, Hull JG (2000) The social psychology of stigma. Guilford Press, New York.

11. Snowden LR, Pingitore D (2002) Frequency and scope of mental health service delivery to African Americans in primary care. Mental Health Services Research 4(3):123-130.
12. Link BG, Cullen FT, Frank J, Wozniak JF (1987) The social rejection of former mental patients: Understanding why labels matter. The American Journal of Sociology 92(6):1461-1500.
13. Vibha P, Saddichha S, Kumar R (2008) Attitudes of ward attendants towards mental illness: Comparisons and predictors. International Journal of Social Psychiatry 54(5): 469- 478.
14. Dudley JR (2000) Confronting stigma within the services system. Social Work 45: 449–455.
15. Goffman E (1963) Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs NJ: Prentice Hall.
16. Jones EE, Farina A, Hastorf AH, Markus H, Miller DT, et al. (1984) Social stigma: The psychology of marked relationships. Freeman, New York.
17. Feldman DB, Crandall CS (2007) Dimensions of mental illness stigma: What about mental illness causes social rejection Journal of Social and Clinical Psychology 26(2):137-154.
18. Corrigan PW, River LP, Lundin RK, Penn DL, Uphoff-Wasowski K et al. (2001) Three strategies for changing attributions about severe mental illness. Schizophrenia Bulletin 27(2): 187-195.
19. Corrigan PW, River LP, Lundin RK, Wasowski KU, Campion J et al. (2000) Stigmatizing attributions about mental illness. Journal of Community Psychology 28 (1): 91-102.
20. Proctor EK (2004) Research to inform mental health practice: Social work's contribution. Social Work Research 28(4): 195-197.
21. Rössler W (2016) The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. EMBO reports 17(9): 1250-1253.
22. Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M (2009) INDIGO Study Group. Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. Lancet 373(9661): 408 -415.
23. Nordt C, Rössler W, Lauber C (2006) Attitudes of mental health professionals toward people with schizophrenia and major depression. Schizophr Bull 32(4): 709-714.
24. Loch AA, Hengartner MP, Guarniero FB, Lawson FL, Wang YP, et al. (2013) The more information the more negative stigma towards schizophrenia: Brazilian general population and psychiatrists compared. Psychiatry Res 205(3): 185-191.
25. Rössler W, Salize HJ, van Osj (2005) Riecher-Rössler A Size of burden of schizophrenia and psychotic disorders. Eur Neuropsychopharmacol 15(4): 399-409.
26. Ostman M, Kjellin L (2002) Stigma by association: Psychological factors in relatives of people with mental illness. Br J Psychiatry 181: 494-498.
27. Oexle N, Corrigan PW (2018) Understanding mental illness stigma toward persons with multiple stigmatized conditions: Implications of intersectionality theory. Psychiatric Serv 69(5): 587-589.
28. Corrigan PW (2005) On the Stigma of Mental Illness: Practical Strategies for Research and Social Change. Washington DC APA, USA.
29. Schnyder N, Michel C, Panczak R, Ochsenbein S, Schimmelmann BG et al. (2018) The interplay of etiological knowledge and mental illness stigma on healthcare utilization in the community a structural equation model. Eur. Psychiatry 51: 48-56.
30. Angermeyer MC, Matschinger H (2005) Causal beliefs and attitudes to people with schizophrenia. Trend analysis based on data from two population surveys in Germany Br J Psychiatry 186: 331-334.
31. McGinty EE, Goldman HH, Pescosolido BA, Barry CL (2018) Communicating about mental illness and violence: balancing stigma and increased support for services. J Health Polit Policy Law 43(2): 185–228.
32. Mannarini S, Boffo M. Anxiety, bulimia (2014) Drug and alcohol addiction, depression, and schizophrenia: What do you think about their etiology, dangerousness, social distance, and treatment? A latent class analysis approach. Soc Psychiatry Psychiatr Epidemiol 50(1): 27-37.
33. Corrigan PW (2000) Mental health stigma as social attribution: Implications for research methods and attitude change. Clin. Psychol Sci Prac 7(1): 48-67.
34. Read J, Haslam N, Sayce L (2006) Davies E Prejudice and schizophrenia a review of the mental illness is an illness like any other approach Acta Psychiatr Scand 114(5): 303-318.
35. Schomerus G, Schwahn C, Holzinger A, Corrigan PW, Grabe HJ, et al. (2012) Evolution of public attitudes about mental illness: A systematic review and metaanalysis. Acta Psychiatr. Scand 125(6): 440-452.
36. Lefley HP (1989) Family burden and family stigma in major mental illness. American Psychologist 44(3): 556-560.
37. Thornicroft G, Brohan E, Kassam A, Lewis-Holmes E (2008) Reducing stigma and discrimination: Candidate interventions. International Journal of Mental Health Systems 2(1): 2-3.
38. Britten N (1998) Psychiatry, stigma, and resistance: Psychiatrists need to concentrate on understanding, not simply compliance. BMJ 317(7164): 963-964.
39. Pescosolido BA, Fettes DL, Martin JK, Monahan J, McLeod JD (2007) Perceived dangerousness of children with mental health problems and support for coerced treatment. Psychiatric Services 58(5): 619-625.
40. Klin A, Lemish D (2008) Mental disorders stigma in the media: Review of studies on production, content, and influences. Journal of Health Communication 13(5): 434-449.
41. Corrigan PW (2011) Best practices: Strategic stigma change (SSC): Five principles for social marketing campaigns to reduce stigma. Psychiatric Services 62(8): 824-826.
42. Parcesepe AM, Cabassa LJ (2013) Public Stigma of Mental Illness in the United States: A Systematic Literature Review. Adm Policy Ment Health 40(5): 384-99.
43. Angermeyer MC, Holzinger A, Matschinger H (2009) Mental health literacy and attitude towards people with mental illness: A trend analysis based on population surveys in eastern part of Germany. European Psychiatry 24(4): 225-232.
44. Liberman RP (1988) Psychiatric Rehabilitation of Chronic Mental Patients. American Psychiatric Association Publishing, USA.
45. World Health Organization (2001) The World Health Report 2001. Mental Health: New Understanding, New Hope. Geneva: World Health Organization, Switzerland.
46. Jablensky A (2017) Worldwide Burden of Schizophrenia (10th ed), Philadelphia: Wolters Kluwer 3666-3697.
47. Hopper K, Harrison G, Janca A, Sartorius N (2007) Recovery from Schizophrenia. An International Perspective. A Report from the WHO Collaborative Project, The International Study of Schizophrenia. Oxford: Oxford University Press, USA.
48. Fabrega H (1991) Psychiatric stigma in non-Western societies. Compr Psychiatry 32(6): 534-51.

49. Ng CH (1997) The stigma of mental illness in Asian cultures. Aust N Zeal J Psychiatry 31(3): 382-90.

50. Shahveysi N, Shoja Shafti S, Fadaie F, Dolatshahi B (2007) Comparison of mental illness stigmatization in families of schizophrenic and major depressive disorder patients without psychotic features. Journal of Rehabilitation 8(29): 21-27.

51. Dols MW (1987) Insanity and its treatment in Islamic society. Med History 31(1): 1-14.

52. Mannarini S, Rossi A (2019) Assessing Mental Illness Stigma: A Complex Issue. Frontiers in Psychology 9: 1-5.

DOI: 10.32474/OJNBD.2021.05.000209