Review

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A Review on Mental Illness and Stigma

Ruhsal Hastalıklar ve Damgalama Üzerine Bir Gözden Geçirme

Nurdan Zühre Çilek[1], Cengiz Akkaya[1]

[1]Uludağ University, Bursa

ABSTRACT

The concept of stigma is a universal problem that has been the subject of many studies. The phenomenon of stigmatization in psychiatric disorders is also an issue that should be particularly emphasized. Studies have reported that the diagnostic groups most exposed to stigmatization are psychotic disorders, bipolar disorders, depressive disorders, anxiety disorders, and substance use disorders. The stigma process is shaped especially by the clinical features of psychiatric disorders and the society's attributions to the causes of psychiatric disorders. In order for the interventions to be developed to prevent stigma to be effective, it is thought that the causes of stigma must first be understood. Therefore, in this study, it is aimed to review the stigmatization processes separately according to the types of psychiatric disorders.

Key words: Psychotic disorders, bipolar disorders, depressive disorders, anxiety disorders, substance abuse

ÖZ

Damgalama kavramı, birçok araştırmaya konu olmuş evrensel bir sorundur. Psikiyatrik hastalıklarda damgalama olgusu da özellikle üzerinde durulması gereken bir konudur. Yapılan araştırmalar damgalamaya en çok maruz kalan tanı gruplarının psikotik bozukluklar, bipolar bozukluklar, depresif bozukluklar, kaygı bozuklukları, madde kullanım bozuklukları olduğunu bildirmektedir. Damgalama sürecini özellikle psikiyatrik hastalıkların klinik özellikleri ve toplumun psikiyatrik hastalıkların nedenlerine yönelik atıfları şekillendirmektedir. Damgalamayı önlemek amacıyla geliştirilecek müdahalelerin etkili olması için önce damgalamaya sebep olan nedenlerin anlaşılması gerektiği düşünülmektedir. Bu nedenle, bu çalışmada psikiyatrik hastalık türlerine göre damgalanma süreçlerinin ayrı ayrı gözden geçirilmesi amaçlanmıştır.

Anahtar sözcükler: Psikotik bozukluklar, bipolar bozukluklar, depresif bozukluklar, anksiyete bozuklukları, madde bağımlılığı

Introduction

Stigma, which is associated with a wide variety of attributes in life such as race, sexuality, physical appearance, psychiatric disorders, and physical diseases, is a universal problem that has been the subject of many studies. When stigma comes into play, especially with psychiatric disorders, emotions such as anxiety, anger, shame, pity and fear emerge. People's attitudes against psychiatric disorders is either reward or punishment oriented, which is shaped by their own emotions (Corrigan 2000, Link et al. 2004). Researches show that the diagnosis groups which are most exposed to stigma is psychotic disorders, bipolar disorders, depressive disorders, anxiety disorders and substance use disorders. It was observed that the stigma levels varied depending on the clinical and demographic characteristics of the related diagnosis groups. The aim of this study is to review the stigma process in psychiatric disorders. In consequence, a detailed search is conducted on the stigma processes in psychiatric disorders in EBSCO, Dergipark, Google Scholar and Wiley Online Library databases. Stigma subjects in psychotic disorders, bipolar disorders, depressive disorders, anxiety disorders and substance use disorders were emphasized in line with the literature during the research. The main difference of this study from the others is that it deals with the phenomenon of stigmatization specifically for each psychiatric disorder.

Respectively, first the stigma phenomenon will be discussed conceptually. Later on, the diagnostic groups that are most exposed to the stigmatizing attitude and which characteristics of these related diagnosis groups are associated with stigmatization will be examined. Finally, the impact of contact and education on stigmatizing attitudes will be briefly mentioned.

Concept of Stigma

The term stigma, which was used for the first time in Ancient Greek, means a hole, a scar, a mark, a stain (Goffman 1963). The concept of stigma, which dates back to the Middle Ages, was first used as an indicator of criminal activities. The "black

Address for Correspondence: Nurdan Zühre Çilek, Uludag University Faculty of Medicine, Department of Mental Health and Diseases, Bursa, Turkiye
E-mail: nzcilek@gmail.com **Received:** 08.02.2022 **Accepted:** 15.05.2022
ORCID ID: 0000-0002-4957-430X

mark" formed as a result of marking the body with a hot iron rod served the purpose of distinguishing criminals from the others (Kaygısız 2016). When we explore stigma from the Middle Ages to the present, we see that it progresses on the basis of more prejudiced and discriminitive behaviors such as avoiding people with certain characteristics, developing negative attitudes against them, and marginalizing them (Özmen and Erdem 2018). While Manzo (2004) defines stigma as an under-defined and overused phenomenon, Goffman (1963) describes stigma as a deeply discrediting attribute, an undesirable difference. He says stigma reduces the individual from an ordinary person to a flawed and despised individual. According to Link et al. (2004), while stigma occurs, the discriminatory stimulus is linked to an undesirable trait. This undesirable trait will discredit the person in the eyes of others. The US Department of Health and Human Services has reported that stigma deprives people of their dignity and interferes with their ultimate participation in society (U.S. Department of Health and Human Services 1999). In the psychology literature, stigmatization is a phenomenon that is mostly dealt with by social psychologists with researches related to the sub-field of social psychology, and it is encountered in subjects such as social attitudes and attitude change strategies (Corrigan 2000, Corrigan et al. 2001).

In general terms, stigma reflects the differentiation from other individuals or social groups, and emphasizes on an abnormality or an existence of a situation that shames a person or a group with some certain characteristics. This person or group is blamed, discredited, humiliated, despised and subjected to discrimination because of their relevant characteristics. Thus, their social desirability shrinks (Link et al. 2004). In most cases, the stigmatized person is given a trait that is not based on reality and is expected to be ashamed of that trait. This attribution, which is based on negative conviction and prejudice, eventually brings discrimination and exclusionary behaviors (Avcil et al. 2016). In essence, when a discriminatory stimulus is noticed, stereotypes act as a mediator for the development of the discriminatory behavior because of cognitive mediation (Corrigan 2000).

It is known that stigma systematically takes place in stages and becomes stereotypical over time (Myers and Dewall 2016). Conceptualizations regarding the stigma process facilitate clear and unambiguous understanding of it. Link et al. (2004) addressed these concepts as labeling, stereotyping, emotional reactions, and discrimination. At first the differences grab people's attention and cause labels. Then, cognition, culture, and religion come into play and the labels attached to differences are connected to undesirable features and negative stereotypes. Thus, the distinction between "us" and "them" becomes possible, and labeled people are exposed to discriminatory behavior (Sayce 1998). Stigmatization is a process that leads to the construction of stereotypes starting from the definition of difference then the inclusion of people defined as different into categories paired with a negative trait, a phenomenon that leads to discriminatory behaviors in many areas of life such as social, economic and political (Link and Phelan 2001). Stigmas about race, sexuality, physical appearance, psychiatric disorders, and physical diseases are interrelated to conditions within daily life. We create stereotypes by bonding these stigmas to undesirable traits. At this stage, the phenomenon conceptualized as cognitive separation comes into play and a distinction is made between 'us' and 'them'. And as a result of cognitive separation, discriminatory behavior occurs. Discrimination is the behavioral manifestation of prejudice (Abdullah and Brown 2011). Associating the stigmatized people with undesired features by keeping them separate from the others is a justification method for devaluing and excluding those (Link et al. 2004). Discriminatory behaviors might occur at an individual level such as while renting an apartment, being recruited, being accused unjustly, being pushed into isolated environments, as well as at a structural level within some institutional practices such as the criminal justice system and health system (Sayce 1998, Abdullah and Brown 2011).

When emotional reactions of the people who are stigmatized and the people who do stigmatize are evaluated separately, studies have reached the following results: The stigmatizing perspective is associated with feelings of fear, anxiety, anger-vexation, and pity. On the other hand; feelings of shame, fear, alienation and anger have been reported from the perspective of the stigmatized people (Weiner et al. 1982, Weiner et al. 1988, Corrigan 2000, Link et al. 2002). The essential emotion of the stigmatized person is an intense embarrassment which causes hurtful results as the studies have shown (Link and Phelan 2001). By and large, stigmatization triggers feelings of shame. This situation prevents those with symptoms from accepting them and from seeking help. On the other hand, it is observed that those who have a psychiatric diagnosis find it burdensome to accept the disorder and they show resistance to the treatment (Wolpert 2001). The emotions of the stigmatizer follow a more complex path. It has been reported that the emotional reactions of the stigmatizer, which is also defined by Weiner's attribution theory, directly affect the behaviors towards the stigmatized individual. People's attributions to the causes of the stigma largely determine what they think about and how they treat the stigmatized individual (Weiner 1982). According to Weiner's theory, perceived controllability and changeability over time determine the emotional responses, and behaviors emerge from the emotional responses. If the people believe that the subject has control over the stigmatizing situation, feelings of anger and, accordingly, punitive behaviors occur. On the other hand if the people think that the subject has no control over the stigmatizing situation, feelings of pity and subsequently the urge to be help the subject emerge (Weiner 1980). Corrigan (2000) deals with Weiner's theory in a review study, within the dimension of physical and psychiatric disorder. According to the results of this study, since physical illnesses are perceived as less controllable, people believe that the individual is not responsible for these physical illnesses, and conduct of support accompanies to the feeling of compassion. Conduct of support is categorized respectively as instrumental support (such as solving a problem), tangible support (such as donating goods), informational support (such as giving advice), and emotional support (such as reassuring). But with psychiatric disorders, things proceed contrastingly. People believe that

the perceived controllability in psychiatric illnesses is high and therefore they believe that the individual is responsible for the symptoms. This concept of responsibility brings about anger and conduct of punishment. Conduct of punishment may exist in the form of reform/rehabilitation, which includes helping the person adapt to society, or in the form of social protection. Changeability over time, which is another principal concept, predicts that the constant continuation of the stigmatizing situation will lead to a decrease in the conduct of aid (Corrigan 2000, Link et al. 2004).

Stigma studies have identified three levels of stigmatization: Social stigma, structural stigma and self stigma (Livingston and Boyd 2010, Abdullah and Brown 2011, Grant et al. 2016). Social stigma exists between social groups on a meso level. The dominant emotion towards the stigmatized person is unworthiness. Avoiding an individual with a psychiatric disorder, seeing him as worthless, perceiving him as dangerous, and pushing him out of social groups are examples for social stigma (Corrigan et al. 2005a). Structural stigma refers to particular policies of large entities (e.g., governments, companies, schools) on macro level. Private and public entities that are authorized in structural stigma limit the rights and opportunities of the individuals by putting forward the institutional rules, policies and procedures. The dominant emotion towards the stigmatized person is inadequacy. For instance job application of an individual with a psychiatric disorder for a private institution may be rejected on the grounds that psychiatric disorders are against the recruitment policies of the institution. With structural stigma, power and status differences are legitimated and social exclusion is maintained (Corrigan et al. 2005b). Self stigma, also called internalized stigma, is experienced at the individual (micro) level. In self stigma, the individual accepts the stereotypes that society imposes on him and sees himself as a devalued member of society. The individual internalizes the feelings of self-worthlessness and inadequacy which he perceives along social and structural stigma by incorporating them in his own personal value system and sense of self (Corrigan et al. 2006). Self stigma perception can alter to self-sabotaging behaviors such as avoiding participating to social activities or quitting job hunting (Abdullah and Brown 2011). The three types of stigmas mentioned are dynamic and in interaction with each other (Park et al. 2013). When the literature is surveyed, it is discerned that the studies on the subject of stigmatization in psychiatric disorders mostly focus on social stigma and self stigma.

Stigma in Psychiatric Disorders

Psychiatric disorders are different from physical illnesses in terms of the stigmatization process. Since it affects human life with its cognitive, emotional and behavioral dimensions, it is believed by others that the essence of the stigmatized individual is different from the others (Wolpert 2001). Stigma levels also vary among psychiatric disorders. The most common diagnosis groups who are exposed to stigma are psychotic disorders, bipolar disorders, depressive disorders, anxiety disorders and substance use disorders (Crisp et al. 2000, Link et al. 2004, Özmen et al. 2004a, Çam and Bilge 2007, Arslantaş et al. 2010, Brohan et al. 2010, Saillard 2010). Each psychiatric disorder is associated with a stigma due to a different feature. For instance, the patients diagnosed with major depression are seen as individuals with weak characters who cannot recover even if they try, patients diagnosed with schizophrenia or with alcohol or substance addiction are stigmatized because they are considered dangerous (Martin et al. 2000). Patients diagnosed with post-traumatic stress disorder, on the other hand, are not exposed to stigmatization within the scope of psychiatric disorders, since the disorder is of external origin (Wolpert 2001). The findings of the studies examined are summarized in Table 1, including the diagnosis groups, the reasons for stigma, and the types of stigma.

Alongside with psychiatric disorders, the consumption of psychiatric medication can also cause stigma. Because the negative effects of psychiatric medications are perceived to be more severe than they actually are (Benkert et al. 1997) and it is believed that they numb the patients (De lasCuevas and Sanz 2007). In a study, it was observed that people generally associate psychiatric drugs with abuse, and antidepressants in particular are perceived as mind-altering and addictive (Stone and Merlo 2010). It seems more acceptable in society to talk about stomach pain or fatigue instead of psychiatric problems (Wolpert 2001).

In a comparison study conducted to see the difference between physical and mental symptoms in terms of the stigmatization process, the diagnosis of major depression and the diagnosis of somatization disorder were compared. The results showed that depressive patients experience much more social stigma than the patients who somatize their complaints. This situation, which is considered as the effect of culture, was associated with more tolerant acceptance of somatic symptoms in the society in which the study was conducted. Therefore, it has been observed that people with depressive complaints are more exposed to social stigma. The society sees somatic symptoms culturally more acceptable than mental symptoms and the general attitude of people is shaped accordingly (Taşkın 2007).

Psychotic Disorders

Among the psychiatric disorders, the diagnosis group most exposed to stigma and accordingly discriminatory behavior is psychotic disorders (Sağduyu et al. 2001, Kocabaşoğlu and Aliustaoğlu 2003, Schulze and Angermeyer 2003, Özmen et al. 2004b). Psychotic disorders are mostly known among the public over the spectrum of schizophrenia, so the stigmatization process takes place over the concept of schizophrenia. Although the society does not have enough and accurate information about the psychotic disorders, myths containing negative beliefs are dominant (Gronholm et al. 2017, Yüksel et al. 2018). Studies have shown that patients diagnosed with schizophrenia are stigmatized by these myths, which are common among the public. The most common myths are as follows: There is no cure for schizophrenia, it is contagious, unpredictable natured people have it, it contains aggression, it means personality division, it is caused by character weakness and lack of will (Üçok 2003).

Studies conducted in different countries show that stereotypes

Table 1. Results of the reviewed publications

Publication	Diagnostic Group	Reason of the Stigma	Type of the Stigma
Üçok 2003, Lee 2002	Psychotic Disorders	Stereotype: Dangerous	Social Stigma
Crisp et al. 2000, Sağduyu et al. 2001, Taşkın et al. 2002, Şah 2012, Doğanavşargil-Baysal 2013, Gronholm et al. 2017, Işık et al. 2019	Psychotic Disorders	Stereotype: Dangerous	Structural Stigma
Yanos et al. 2008, Norman et al. 2011, Yıldız et al. 2012, Sevindik et al. 2014	Psychotic Disorders	Negative attitudes of the society	Internalized Stigma
Lolich et al. 2010	Bipolar Disorders	Presence of psychotic features	Social Stigma
Goodwin and Jamison 1990, Perlick et al. 2001, Rüsch et al. 2008, Çam and Çuhadar 2013, Üstündağ and Kesebir 2013	Bipolar Disorders	Negative attitudes of the society	Internalized Stigma
Aydemir 2004	Bipolar Disorders	Early onset	Internalized Stigma
Üstündağ and Kesebir 2013	Bipolar Disorders	Having a rapid cycle and a seasonal trend	Internalized Stigma
Taşkın 2007a	Bipolar Disorders	The recurring and chronic nature of the disorder	Internalized Stigma
Pyne et al. 2004	Depressive Disorders	Changes in psychomotor activity and increased symptom severity	Social Stigma
Wolpert 2001, Özmen et al. 2004	Depressive Disorders	Stereotype: Weakness	Social Stigma and Internalized Stigma
Pyne et al. 2004	Depressive Disorders	Believing that depression is a brain-related disorder	Internalized Stigma
Wolpert 2001, Brohan et al. 2011, Coppens et al. 2013, Sevindik et al. 2014, Kaya 2017	Depressive Disorders	Negative attitudes of the society	Internalized Stigma
Grant et al. 2016	Anxiety Disorders	Increased symptom severity	Internalized Stigma
Davies 2000, Batterham et al. 2013, Grant et al. 2016	Anxiety Disorders	Negative attitudes of the society	Internalized Stigma
Arıkan et al. 2004	Substance Use Disorders	Seeing it as a weakness of morality and willpower and believing that it is a personality problem	Social Stigma
Crisp et al. 2000, Janulis et al. 2013	Substance Use Disorders	Stereotype: Dangerous	Social Stigma
Ögel 2004	Substance Use Disorders	The idea that women represent the integrity of morality and family structure	Social Stigma
Crisp et al. 2000	Substance Use Disorders	Stereotype: Dangerous	Structural Stigma
Can 2012, Kaya-Yüksel 2015	Substance Use Disorders	Negative attitudes of the society	Internalized Stigma

similar to these myths are common. Studies conducted in culturally dissimilar countries, such as Australia, India, Singapore, Canada, England and Turkey, mention similar attitudes towards the patients with psychotic disorders (Lee 2002). The findings show in general that these patients are perceived as dangerous, and therefore people are quite reluctant to establish social intimacy with them. Moreover, the participants stated that they avoid establishing close relationships not only with the patients but also with their families (Crisp et al. 2000, Dietrich et al. 2004, Taşkın 2004, Thornicroft 2014). Structural stigma is also more common in psychotic disorders in which social rejection and social stigma are tremendously high compared to other diagnostic groups. The patients face serious complications such as social rejection, loss of social status, isolation from the society, and employment difficulties (Jorm et al. 1997, Crisp et al. 2000, Sağduyu et al. 2001, Taşkın et al. 2002, Taşkın et al. 2003, Taşkın 2007, Doğanavşargil-Baysal 2013, Duman-Çetinkaya and Bademli 2013, Thornicroft 2014, Demirören et al. 2015,

Gronholm et al. 2017, Işık et al. 2019).

The 'dangerous' stereotype is the foremost reason why so much social stigma is seen in the schizophrenia spectrum. People diagnosed with schizophrenia are perceived as 'dangerous' because they are considered as unpredictable people (Sartorius et al. 2010). The negative attitudes of the society due to the perception of 'danger' also reinforce the perception of self stigma in patients (Yanos et al. 2008, Yıldız et al. 2012). As a result of the internalization of stigma, the emotions of the patients with psychotic disorders due to stigma are conceptualized as "tainted perception of identity" (Stuart and Arboleda-Florez 2012, Ong et al. 2016, Özmen and Erdem 2018).

Bipolar Disorder

It is known that the people diagnosed with bipolar disorder experience non-adherence to the treatment due to the recurrent and chronic nature of the disorder (Oral et al. 2002).When it comes to stigmatization, findings show that the continuity of the pathology is more decisive than its severity (Taşkın 2007). The emergence of bipolar disorder in the form of periods, especially when seasonal features come into play, causes the people around the patient to attribute the symptoms of the disorder to the personality of the patient (Üstündağ and Kesebir 2013). When the patient experience symptoms of the disorder in certain periods, the people frequently think the symptoms in these periods are a part of the personality of the patient, rather than suggesting that the patient is having episodes. This situation forces the patients to the demand of restricting their lives under constant control; therefore they try to develop a strict control mechanism (Aydemir 2004).

In a study that examined stigma by taking bipolar disorder episodes into consederation, it was seen that the amount of depressive episodes had been associated with self stigma perception (Rüsch et al. 2008). Üstündağ and Kesebir (2013); compared depressive, manic, hypomanic and combined episodes and saw that the number of depressive episodes was higher in people with internalized stigma perception in their study. Consistent with the stigma literature in major depression, the increased number of depressive episodes in bipolar disorders is associated with variable stigmas such as functionality level (Goodwin and Jamison 1990), self respect (Marcussen et al. 2010) and quality of life (Gazalle et al. 2007).

Other variables associated with the stigmatization process in bipolar disorder are as follows: Early onset nature, presence of psychotic features, seasonal course of the disorder and having a rapid cycle. The negative effect of the early onset disorder is that the behaviors developed during the seizures and the observed emotional oscillations are evaluated as some characteristics of the personality rather than the symptoms of the disorder. In addition, the early onset of the disorder was associated with self stigma (Aydemir 2004). Patients are exposed to social stigma due to their psychotic features observed during the episodes (Lolich et al. 2010).The rapid cycle and the presence of seasonal characteristics prevent the society from seeing the symptoms of the disorder as a situation that possibly had developed due to a previous trauma or a stressor. When the society observes that the symptoms of the disorder arise independently from life events, the society starts to stigmatize the individual. All of these elements negatively affect the treatment process of the disorder and decrease the level of response to the treatment (Sajatovic et al. 2008). In a study, it was observed that patients diagnosed with bipolar disorder were exposed to statements such as "You are always like this in this season", "This has become your character now", and the patients have complained about these statements (Goodwin and Jamison 1990).

Depressive Disorder

Depressive disorders are among the most common psychiatric disorders. Depressive disorders differ from the usual emotional fluctuations against the difficulties in daily life and can directly impair the functionality of the affected person (Dietrich et al. 2004, Göktaş et al. 2020). People suffering from depressive disorders often have trouble talking about this process. This is due to the nature of the disorder as well as being affected by environmental factors. The people who have never been diagnosed with a depressive disorder in their lifes commonly consider depression as a weakness which is difficult to understand. This behaviour of the society affects how the people diagnosed with depressive disorder evaluate their own depression, and one of the serious consequences of this is self stigma (Kaya 2017). Society's attribution to depression as a weakness pushes the people with the diagnosis to see the depression as something to be ashamed of and they tend to try to hide it. Because the people's thoughts about the weakness make the patient think that the patient has more control over his own problems and makes him feel more responsible. The tendency to conceal may prevent patients from receiving appropriate treatment by causing their attitude to be more reticent. Therefore, social stigma and self stigma create a vicious circle in which patients feel entrapped (Wolpert 2001).

In a study covering thirteen European countries, it was observed that people diagnosed with depressive disorder felt stigma whilst in society, and these individuals reported that they were exposed to discriminatory behaviors (Brohan et al. 2011). In another study, in which attitudes towards depression and its treatment in four European countries examined, it was determined that social stigma existed in every society. Also the patients reported self stigma (Coppens et al. 2013).

In a study comparing those who have previously been diagnosed with depressive disorder and have been treated for this reason, and those who have never been diagnosed with a depressive disorder before, it has been found that diagnosed people think that depression is a disease related to the brain, and this belief increases the sense of self stigma (Pyne et al. 2004). It is thought that this situation may be related to cognitive distortions such as the the opinion of worthlessness and the guilt experienced during the depressive process (Aromaa et al. 2011). In their study, Pyne et al. (2004) found that the perception of social stigma is more related to changes in psychomotor activity than the opinion of worthlessness. Changes in psychomotor activity and increasing

depression severity have been interpreted as the main reasons of the more socially stigmatizing events (Pyne et al. 2004).

Anxiety Disorders

Anxiety, which is the major emotion of the stigmatization process, takes a more compound course when examined over the subject of stigma in anxiety disorders. Therefore, it is very important to define the symptomatology. In addition to the existing anxiety symptoms, since patients with anxiety disorders also have anxiety about being stigmatized by their environment, this also affects their behaviours regarding a request for help in a negative way. This situation, which causes an increase in anxiety symptoms, puts patients in a vicious circle (Grant et al. 2016).

Studies on stigma have focused on serious psychiatric disorders such as depressive disorders and psychotic disorders. On the other hand, anxiety disorders which are considered less serious are neglected in stigma. While self stigma is frequently seen in anxiety disorders, research on stigma is very limited in anxiety disorders (Barney et al. 2006).

People diagnosed with anxiety disorder are prone to self-stigma and are therefore more affected by the negative consequences of self stigma. Fears of rejection trigger the need for approval from the others, which results with low self-esteem (Davies 2000). Although they show symptoms of anxiety, there are delays in the behavior of seeking help in order not to be stigmatized, which causes the problems to become chronic. The patients perceive each symptom diagnosed in anxiety disorder as a stigma that lowers their self-esteem and this stigma damages their belief in the improvement of their condition. These beliefs cause negative effects on both psychotherapeutic and pharmacotherapeutic care of the patients (Ociskova et al. 2013).

According to the results of a study examining the variations of stigma in anxiety disorders according to demographic and clinical characteristics, self stigma is less common in women. In addition, showing anxiety symptoms for the first time and the increase in symptoms were associated with an increase in the level of self-stigma (Batterham et al. 2013, Grant et al. 2016). Those who live in rural areas feel social stigma more (Batterham et al. 2013). In another study, it was observed that depression accompanying anxiety disorder doubled the level of self stigma (Alonso et al. 2008).

Substance Use Disorders

It is known that society perceives substance use disorders as dangerous as psychotic disorders (Crisp et al. 2000). In a study by Crisp et al. (2000), which compared alcohol and substance use disorders, it was stated that substance addicts were more likely to face negative attitudes and were more socially stigmatized. Another remarkable discovery about stigma related to substance use is that different substances cause different levels of stigma. If the substance used is not legal, the use of this substance is associated with adversary and crime by the society (Janulis et al. 2013). In addition, the high consumption of alcohol and substances and its permanency is considered by people as loss of control mechanism and cause social stigma. It is thought that people who lose their control will have difficulty in making decisions about their lives and will not be able to get married (Rasinski et al. 2005). The dismissive demeanors within the general attitude of the society causes self stigma (Can 2012, Kaya-Yüksel 2015).

The phenomenon of stigma functions differently from other psychiatric disorders when examined from the perspective of substance use disorders. The people do not discern alcohol and substance addiction as a disorder and interpret addiction as a weakness of personality and willpower. This is considered as a voluntary mistake by the society (Arıkan et al. 2004). The society's attitude towards the addiction prevents the patients from accepting their illness and adapting to the treatment. The patients do not accept the diagnosis of alcohol and substance addiction in order to avoid negative judgments and stigmatizing attitudes (Luoma 2013).

During the stigmatization process of alcohol and substance addiction, some demographic characteristics also come into play. Another study shows that people with low economic status are exposed to more social stigmatization than those with high economic status (Luoma 2007). Another main difference is in gender. In particular, women are exposed to much more social stigma than men and are labeled harsher if they are a mother or pregnant. The reason of this situation stems from the cultural perception of women. They are considered as represantatives of morality in the society, therefore alcohol and substance use disorder in women is regarded contrary to moral values. In addition, since it is believed that the women represent the integrity of the family institution; their addictions are considered against family values (Ögel 2004).

Contact and Education While Struggling Against Stigma

When the relevant literature is examined, it has been determined that the stigmatization process is affected by various variables according to the type and nature of the psychiatric disorders, and the intensity of stigmatization depends on these variables. Each psychiatric disorder has a social response according to its nature and symptoms. Many variables such as culture, clinical characteristics, and demographics affect the attitude of the society towards the related psychiatric disorder and trigger various behaviors (Çam and Bilge 2013, Grant et al. 2016). The general attitude and approach of the people is reflected in their behavior towards the people diagnosed with psychiatric disorders, and this situation causes patients to feel stigmatized by internalizing their diagnosis. It is known that stigma alienates patients from social life, causes a decline in their self-esteem and confidence, creates sentiments of alienation and exclusion, prevents their accommodation and job opportunities, and causes loss of status. Everything becomes more strenuous to overcome for the patient and the society, especially when the stigmatization is internalized (Corrigan 2000, Link et al. 2004). For this reason, it is emphasized that multi-level intervention programs that

develop new strategies to prevent both social stigma in the society and patients' internalization of these stigmatizations would be highly effective (Kocabaşoğlu and Aliustaoğlu 2003, Taşkın 2007, Collins et al. 2013).

When the phenomenon of stigma is evaluated in terms of psychiatric disorders, there are two important conditions that stand out for changing the stigmatizing attitude: Education and contact (Trute et al. 1989, Penn et al. 1999, Blascovich et al. 2001, Corrigan et al. 2001, Link et al. 2004, Pinto-Foltz and Logsdon 2009, Sartorius et al. 2010, Collins et al. 2013, Çam et al. 2014, Thornicroft 2014, Avcil et al. 2016, Grant et al. 2016). Education aims to change the stigmatizing attitudes of the society by replacing the myths about psychiatric disorders with correct notions. Contact, on the other hand, aims to challenge the stigmatizing attitude by interacting directly with people diagnosed with psychiatric disorders (Corrigan and Penn 1999).

The findings of studies show that contact-based intervention programs reduce the effects of structural stigma and self stigma. Interpersonal interaction has contributed to the change of stigmatizing attitude in the society, and this prevented the patients from feeling stigmatized (Thornicroft et al. 2016). The main purpose of contact-based interventions is to show people with psychiatric disorders through experience that they can live a more fulfilling life despite their disorder. Thus, patients' hope and belief in treatment will increase (Corrigan et al. 2013, Corrigan et al. 2014). Recent studies have shown that video interventions regarding contact can also be as effective as face-to-face interaction (Janouskova et al. 2017, Koike et al. 2018). In two studies aiming to reduce stigma against psychiatric disorders with contact-based video intervention, the intervention technique was found to be effective on structural stigma. Video-based interventions seem particularly suitable for the young population between the ages of 18-30 (Amsalem et al. 2020, Amsalem et al. 2021). Augmenting face-to-face interactions in small groups can be difficult depending on the circumstances. Evidence of the effectiveness of video-based interventions is valuable because they are able to reach wider populations and are less costly (Amsalem and Martin 2022).

Studies conducted with participants from various sections of the society have shown the effectiveness of anti-stigma education programs (Patrick et al. 2002). The stigmatization levels of mukhtars (Çam et al. 2014), medical school students (Ay et al. 2006), care center workers (Gökmen and Okanlı 2017), nurses (Duman and Günşen 2017), and high school students (Schulze et al. 2003) against psychiatric disorders have shown significant decrease before and after their participations in training programs. Thanks to anti-stigma training programs, practical developments have been observed on attitudes and beliefs towards psychiatric disorders. Chung et al. (2001) emphasize the importance of including anti-stigma education programs in undergraduate education.

Studies have shown that short-term training programs are effective in changing the stigmatizing attitude (Eker 1989, Pinfold et al. 2003); and that contact strategies are more effective than educational strategies in order to create longer-term behavioral changes (Arkar and Eker 1992, Pinfold et al. 2005, Kanaak et al. 2014, Thornicroft 2014, West et al. 2014). The common opinion of all the studies mentioned in this article is that changing the stigmatizing attitude is a long-term process that cannot be resolved easily and it requires reaching everyone in the society (Çam and Bilge 2013).

Conclusion

Stigma and discriminatory behavior due to stigma have existed as a universal problem for many years. When it comes to psychiatric disorders, it has been observed that the intensity of stigma is affected by various variables. Clinical and demographic characteristics, especially culture, can also manage the stigmatization process according to the type and the nature of psychiatric disorder. Although the beliefs and judgments of the society vary according to the type and the nature of psychiatric disorders, when we look at the literature within the framework of social attitudes, stereotypes of dangerousness and weakness draw attention.

When the concept of stigmatization is reviewed in a historical context, it is seen that false information and beliefs shape social attitudes. From this point of view, it is thought that the struggle against stigma should commence from changing false information and beliefs. In line with various studies, situations and features that appear to have a role in the stigmatization process should be carefully addressed. Determinate knowledge about the types and nature of psychiatric disorders will have an impact on the behavior of the society. Implementation of contact and training programs on different elements and social groups of the society and designation of the contents of the programmes in accordance with the structure of these different elements and social groups of the society will facilitate the process of the struggle against stigma. Intervention programs at the societal level will have positive effects on self stigma as well as on social and structural stigma.

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