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Evaluation of Stigma of Mental Illnesses: Review

Ruhsal Hastalıklara Yönelik Damgalamanın Değerlendirilmesi: Gözden Geçirme

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ABSTRACT

Stigma is the society's development of prejudiced attitudes and behaviors against the individual due to the diagnosis and treatment associated with mental illnesses, and the individual's exposure to discrimination within the social group. Stigma can be observed as social and internalized. Social stigma can limit people's opportunities, options and competitive conditions. Internalized stigma is the internalization of beliefs related to the prejudiced and discriminatory approach of the environment by the individual. Social and internalized stigmatization processes are related to self-esteem. Patients' relatives are also exposed to stigmatization along with individuals who have mental illness, and stigmatization reduces the possibility of recovery in mental illnesses. Considering the relevant research findings, it is understood that there is a need to struggle individually and socially against stigma in order to prevent the increase in the negative consequences of mental illness and the development of comorbidities, to strengthen functional behaviors during the treatment process and to increase social support. Informing patients, patient's family, mental health workers and the society, encouraging social change and new research on the subject can be considered as methods of struggle with stigma. In this review, the stigmatization process, social and internalized stigma, the relationship between psychopathology and self-esteem with internalized stigma, stigma and the patient's family, status of stigma over time, status of stigma according to societies, and the relationship of stigma with mental health services were evaluated.
Keywords: Mental illness, mental health, stigma, prejudice, discrimination

ÖZ

Damgalama ruhsal hastalıklarla ilişkili tanı ve tedaviden dolayı toplumun kişiye karşı önyargılı tutum ve davranışlar geliştirmesi, bireyin sosyal grup içinde ayrımcılığa maruz kalmasıdır. Damgalama toplumsal ve içselleştirilmiş olarak gözlenebilir. Toplumsal damgalama kişilerin fırsatlarını, seçeneklerini ve rekabet koşullarını kısıtlayabilir. İçselleştirilen damgalama çevrenin ön yargı ve ayrımcılık içeren yaklaşımıyla ilişkili inançlarının birey tarafından içselleştirilmesidir. Toplumsal ve içselleştirilen damgalama süreçleri benlik algısıyla ilişkilidir. Ruhsal hastalığı olan kişilerle birlikte hasta yakınlarının da damgalamaya maruz kaldığı; damgalamanın ruhsal hastalıklarda iyileşme olasılığını azalttığı açıklanmıştır. İlgili araştırmaların bulguları dikkate alındığında ruhsal hastalığın olumsuz sonuçlarının artmasını ve eş tanıların gelişmesini önlemek, tedavi sürecinde işlevsel davranışları güçlendirmek ve sosyal desteği arttırmak için damgalama ile bireysel ve toplumsal olarak etkin mücadeleye ihtiyaç olduğu anlaşılmaktadır. Hastaları, hasta yakınlarını, ruh sağlığı çalışanlarını ve toplumu bilgilendirmek; sosyal değişimi ve konuyla ilgili yeni araştırmaları teşvik etmek mücadele yöntemleri olarak düşünülebilir. Bu gözden geçirme çalışmasında damgalama süreci, toplumsal ve içselleştirilen damgalama, psikopatoloji ve benlik algısının içselleştirilen damgalama ile ilişkisi, damgalama ve hastanın ailesi, damgalamanın zamansal ve toplumsal durumu, damgalamanın ruh sağlığı hizmetleriyle ilişkisi değerlendirilmiştir.
Anahtar sözcükler: Ruhsal hastalık, ruh sağlığı, damgalama, önyargı, ayrımcılık

Introduction

The services provided by mental health professionals have complicated aspects; they may also have harmful aspects sometimes, patients may avoid treatment due to stigmatization concerns and those who receive treatment may be exposed to discrimination (Thornicroft et al. 2010). According to the theory of social cognition, stigmatization is a multi-dimensional construct that covers cognitive, emotional and behavioural elements. It is the general beliefs about the characteristics and behaviors of people categorized as the members of a particular social group (Corrigan and Kleinlein 2005, Corrigan and Shapiro 2010). Stigmatization is the devaluation, neutralization, exclusion and discrimination of the individual within the social group or social environment he/she is in (Ersoy and Varan 2007). Stigmatization covers lack of knowledge (limited knowledge), attitude problems (bias) and behavioural problems (discrimination). Emotions such as anxiety, anger and

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resentment along with negative thoughts are bias reactions. Discrimination is observed as behaviors of rejection and avoidance (Thornicroft et al. 2007). Discrimination occurs as a behavioural consequence of bias and that it is punitive (Corrigan 2016). It has been pointed out that stigmatization consists of the processes of coping, social support and making meaning and may have positive or negative consequences depending on the reactions that occur in the related processes (Frost 2011). It has also been emphasized that the possible risks of stigmatization should be discussed (Rüsch et al. 2005).

Stigmatization is a gradual process associated with personality traits and different social resources. A series of stages including unpredictable stereotype behaviors, biases supporting these behaviors, emotional reactions, loss of social position and discrimination have been reported (Schomerus et al. 2012). According to another explanation, in the first stage, with the sudden emergence of some characteristics in a person, this person's differences are distinguished from other people and labelled. Later, these differences are associated with negative stereotypes. There is an obvious discrimination against the individual in the next stage. Loss of rights and status are experienced in the last stage (Link and Phelan 2001). Stigmatization consists of three stages according to another study: the first stage is fear and exclusion. The second stage is authoritarianism and the third stage is helping (Angermeyer et al. 2004). In another study, stigmatization was evaluated to have a three-factor construct relating to potential gains of discrimination, disclosure and mental illness (King et al. 2007).

There are studies developed to evaluate the stigma-related experiences and behaviors of individuals with mental illness. Consumer Experiences of Stigma Questionnaire developed by Wahl (1999) has three parts. Discrimination part has twelve items and stigmatization part has nine items. The third part includes demographic and diagnostic information. Stigmatization Scale (SS) developed by King et al. (2007) includes 28 items and three factors as explanation, discrimination and positive aspects. 12-item Devaluation and Discrimination Scale and 11-item Rejection Experience Scale were developed by Bjorkman et al. (2007). Ritsher et al. (2003) developed the 29-item The Internalized Stigma of Mental Illness Scale (ISMI) which included five subscales as alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. The scale was adapted into Turkish by Ersoy and Varan (2007). The dimensions of lack of knowledge, bias and discrimination were expressed regarding stigmatization (Thornicroft et al. 2007). The first version of Discrimination and Stigmatization Scale (DISC) was created based on the discrimination dimension of stigmatization in international discrimination and stigmatization studies (Thornicroft et al. 2009) in which the difficulties regarding stigmatization experienced by individuals with mental illness were researched. Studies on analysing the psychometric characteristics of the scale and creating the 22-item final form which included the sub-dimensions of biased attitude, self-containment, coping with stigma and positive discrimination were conducted by Brohan et al. (2013). Bakolis et al. (2019) developed an 11-item short version (DISCUS) of the related scale (DISC). In a study which included 1195 participants diagnosed with depression, bipolar disorder, schizophrenia and anxiety disorder who were from 15 different countries including Turkey, psychometric characteristics of the short form (Short-Form DISCUS) developed by Bakolis et al. were analyzed. It was reported that the scale was a valid and reliable tool that allowed one-dimensional evaluation of discrimination experienced (Brohan 2022).

People's limitations of understanding and explaining complaints related with mental health, individuals' experiencing anxiety or fear in the face of incomprehensibility or uncertainty of illnesses and attitudes and behaviors not considered appropriate by the society drive patients away from the society (Taşkın 2007). In a study conducted by Wahl (2012) on a study group of hundred individuals with stigmatization experience, it was reported that social rejection and avoidance behaviors towards patients were observed in some individuals who were within the social circles of patients. It was reported that patients experienced social exclusion such as decrease or cessation of invitation from friends and decrease in social invitations and visits. Patients suffer from symptoms of stigmatization. When patients who seek for treatment experience stigmatization in addition to their complaints, their distress increases. Stigmatization can worsen the disease's course and reduce patients' possibility to recover (Thornicroft et al. 2007, Wahl 2012).

Stigmatization can impair positive self-perception and adherence to treatment about mental health, increase the level of treatment avoidance and reduce individuals' quality of life (Martinez et al. 2018). As a result of stigmatization, patients may experience difficulties in getting a place in working life or in setting new goals in career development in addition to the difficulties they are exposed to in their psychosocial lives. It is understood that individuals who receive help on mental health are likely to experience stigmatization. This review evaluates studies examining stigmatization related to mental illnesses. The aim is to contribute to the discussion and research of the topic. Related concepts were clarified. Results of studies conducted and suggestions according to the evaluation of data assessment were included.

Method

Within the scope of the study, articles examining stigmatization in relation to mental illnesses published between 1999 and 2022 were reviewed. Due to the limited number of studies on the topic, studies conducted after 1999 were included. Studies conducted on mental health were reviewed on "Scopus", "Web of Science", "Google Scholar" for international studies, while "TÜBİTAK ULAKBİM" was reviewed for national studies. Search keywords are as follows: mental illness, mental disorders, stigma, prejudice, discrimination. The search which took place between November 2021 and May 2022 included English and Turkish studies published in peer-reviewed journals. Since stigma was examined in relation to mental illnesses, studies published in fields other than mental health were not included; studies which were on mental health were included in the study. A total of 84 studies were reviewed.

Results

Social and Internalized Stigma

When the processes of experiencing stigma are considered, two different types of stigma as social and internalized have been defined. Severe mental illness can be like a double-sided sword. While coping with distressing situations caused by symptoms on the one hand, it may be necessary to cope with difficulties caused by social stigmatization on the other hand (Corrigan and Kleinlein 2005). Social stigma can develop through learning in the form of acculturation within the social structure of the individual. Adult attitudes and behaviors towards patients' exposure to social stigmatization may lead individuals in developmental age to learn about social stigma. It has been stated that social stigma has three dimensions as stereotype, bias and discrimination (Rüsch et al. 2005). In a study examining these dimensions related with social stigma, it was stated that stereotypes are associated with indifference and threat, bias is associated with fear, and discrimination is associated with restriction (Nieweglowski et al. 2019). In a study which aimed to develop a social stigma model related with depression in adolescents showed a seven-factor stigma model as dangerousness, warmth and competence, responsibility, negative qualities, prejudice, class discrimination and friend discrimination. It was stated that these factors represented the implicit structures of stereotype, bias and discrimination dimensions (Silke et al. 2016).

Social stigma is associated with the interaction between stigmatized and non-stigmatized individuals and the opportunities of individuals exposed to stigma are structurally limited by cultural norms and institutional policies (Hatzenbuehler 2016). Social stigma includes forms of structural discrimination. These are institutional discriminations and they may occur intentionally and unintentionally. They include private and official organization policies that restrict individuals' opportunities and options. Patients affected by the process of stigmatization may not benefit from equal competition terms (Corrigan et al. 2004). In recruitment and in the sharing of authority and responsibility, patients may become disadvantageous and experience loss of rights. In a study conducted to develop an intervention program to reduce the negative effects of social stigma for individuals with substance abuse, there were 29 individuals in the intervention group, while there were 38 individuals in the control group. It was reported that the intervention program contributed to reducing the negative consequences of social stigma and developing expected behaviors (Atlam and Çoşkunol 2019). In a study including a total of 197 participants with pre-test-post-test control group, the effects of an intervention program to reduce the levels of exposure to stigma in patients with obsessive-compulsive disorder were examined. It was reported that psycho education and interaction strategies significantly reduced negative beliefs related with stigma in application group participants (Gürbüz et al. 2020). In a study including 486 participants, attitudes towards mental illnesses, related predictors and the associations of these variables with social stigma were examined. It was found that higher level of education, professional status and life experience related to mental illnesses were associated with mental illness acceptance behaviors (Buizza et al. 2017). In a different study, it was stated that awareness related with the devaluation of individuals with mental illness was associated with high level of education (Mora-Ríos and Ortega-Ortega 2021).

Internalized stigma is the internalization of stereotyped attitudes and behaviors towards individuals by their environment over time. This internalization process may affect individuals' self-evaluation in relation to their sense of self (Kapıkıran and Kapıkıran 2013). It has been stated that self-stigmatization may negatively affect interpersonal relationship experience, receiving help about diseases and self-disclosure behaviors (Eisenberg et al. 2009). Stages of internalized stigma have been put forward: Individuals receiving mental health treatment are considered to be weak in the society. In the first stage "awareness", individuals realize this situation. In the

second stage "agreement", individuals accept the correctness of the related attitude. In the next stage "implementation", the process develops in the self. In the final stage "harming", level of self-esteem and self-efficacy decrease significantly (Corrigan and Rao 2012). Individuals' personality traits, level of social support received and coping skills may have a role within the process.

With the initiation of mental health diagnosis and treatment, stigmatization risks may arise. The process of awareness may start with the behaviors of individuals in psychosocial life and changes in institutional policies. Adapting coping behaviors may not be observed against stigma experienced during the stage of agreement. During the implementation stage, beliefs related to stigma experienced in self-perception may develop. These beliefs may feed the related attitudes. Attitudes can reinforce the behaviors of the social environment that plays a role in the stigmatization process. In the harming stage, individuals experiencing internalized stigma may show maladaptive behaviors and attitudes in their professional, personal and social lives.

In a study examining the relationship of depression and anxiety with internalized stigmatization in patients diagnosed with hemifacial spasm, cross-sectional observations were made in the control group which consisted of 27 patients and 36 healthy individuals. It was reported that depression and anxiety were common in patients diagnosed with hemifacial spasm and these patients experienced significant psychosocial difficulties related with internalized stigma (Değirmenci 2022). In a study with a study group consisting of a total of 19 patients, 16 diagnosed with schizophrenia, 1 diagnosed with schizoaffective disorder and 2 diagnosed with bipolar disorder, the relationship of assertiveness skills training applied to chronic psychiatric patients with patients' self-esteem and internalized stigma levels was examined. It was reported that assertiveness skills training contributed to increasing patients' self-esteem and coping with internalized stigma (Ceylan et al. 2021). In a study examining the relationship between explaining the presence of a mental illness to a social environment and life quality and recovery, 100 participants diagnosed with mental illness were included. Attitudes and attainments related with explaining, quality of life, recovery, privacy, social withdrawal, internalized stigma and depression symptoms were evaluated before starting the implementation, in the third week and in the six week. It was reported that explaining the presence of a mental illness contributes to the processes of receiving social support, increasing quality of life and recovery (Mayer et al. 2022). In a study examining the relationship between personality and stigmatization towards mental illnesses, a three-factor construct emerged as weak/non-sick, dangerous/unpredictable and social distance. It was found that personality traits of compliance and being open to experience were negatively correlated with all of the three factors, while the personality trait of extroversion was positively correlated with weak/non-sick, and conscientiousness and neuroticism personality traits were positively correlated with social distance. It has been stated that different personality traits are associated with stigma in different ways (Yuan et al. 2018).

The Relationship of Psychopathology and Self-Perception with Internalized Stigma

In a study conducted with 35 individuals who were diagnosed with chronic schizophrenia, level of insight was found to be low in individuals with high level of internalized stigma (Dikeç and Kutlu 2014). In a study which included 167 schizophrenia patients, 86 major depression patients and 45 schizophrenia patient relatives, differences were found between schizophrenia patients and major depression patients in terms of stigmatization; it was found that schizophrenia patients had high level of stigmatizing others (social stigmatization), while major depression patients had high level of self stigmatizing (internalized stigmatization) (Yıldız et al. 2012).

In a study including 50 bipolar mood disorder patients and 50 schizophrenia patients, stigmatization experiences of patents were examined. Similar results were found in biased attitude sub-dimension of Discrimination and Stigmatization Scale (DISC) used in the study, and it was reported that both patient groups were exposed to stigma and discrimination. Schizophrenia patients were found to have higher scores in self-containment, coping with stigma and positive discrimination sub-dimensions (Kumar et al. 2020). In a study including 1560 participants from the general population in Finland, depressed individuals were more tolerant when compared with individuals who had mental health problems, and of the depressed individuals, those who used mental health services were less willing to be socially distanced to individuals with mental health problems when compared with those who did not use mental health services (Aromaa et al. 2011). In a study conducted on 1237 individuals receiving mental health services in USA San Diego, it was reported that mostly young individuals and women were exposed to stigmatization and individuals with mood disorders were more uneasy about explaining their illness when compared with schizophrenia patients while no significant difference was found in the level of discrimination experienced about stigmatization (Sarkin et al. 2015). Duration of mental illnesses, the state of hospitalization and level of education were reported to be associated with internalized stigmatization level (Coşkun and Güven Caymaz 2012). In a study examining the correlations between

internalized stigmatization, self-esteem and perceived level of social support in a study group including 162 schizophrenia patients and 200 bipolar disorder patients, correlations were reported between low self-esteem and low perceived social support and internalized stigmatization (Kök and Demir 2018). In another study, higher internalized stigmatization was reported in illiterate men who had at least one hospitalization a year (Tel and Ertekin Pınar 2012).

Correlations were found between stigmatization processes and personality traits such as locus of control and self-perception. It was stated that avoidance, perceptions of inadequacy and shame that develop in the self-perception of the individual with social stigmatization were associated with internalized stigmatization (Çam and Çuhadar 2011). It was reported that self-esteem decreased as the level of internalized stigmatization increased (Tel and Ertekin Pınar 2012) and there was an inverse correlation between level of stigmatization and self-esteem (King et al. 2007). In a study examining the stigma-related states of caregivers of schizophrenia, bipolar disorder and major depressive disorder patients, it was reported that caregivers of schizophrenia patients experienced higher levels of internalized stigmatization than caregivers of bipolar disorder and major depressive disorder patients and that internalized stigmatization was correlated with self-esteem and diagnosis (Chang et al. 2017). It can be understood that self-perception is correlated with internalized stigmatization. Studies to increase the self-esteem of patients during the treatment process can contribute to patients' mechanisms of coping with stigmatization (Kök and Demir 2018).

Stigmatization and Family

Stigmatization can also include other people the patient is associated with (Moses 2014). It was frequently stated that family members of individuals experiencing substance abuse or a different mental illness were harmed in relation to stigma (Corrigan et al. 2006). In a study conducted with 487 participants in 24 different countries, stigmatization was reported to be a problem in terms of patient relatives and family members. Decreased self-esteem and self-confidence, damage to family relationships, difficulties in making friends and maintaining friendships, difficulties in accepting the illness and finding job were reported as stigma-related complaints (Wahl and Harman 1989, cited from Wahl 1999). In a study including 968 participants in which attitudes towards family members of mental illness patients were examined, a more negative attitude was reported to relatives of patients with substance abuse when compared with patients of other mental illnesses. It was reported that family members were blamed for the onset of illness and they were excluded in terms of social relationships (Corrigan et al. 2006). In a study conducted in Ethiopia to examine stigmatization in traditional and rural societies, it was found that 75% of the participants experienced stigma related with a member of the family who had mental illness and 42% were worried about being exposed to discrimination. It was found that 37% of the participants kept the mental illness of the family member as a secret from the social environment and participants living in cities and those older than 45 years of age were affected more negatively by stigmatization (Shibre et al. 2001).

Stigmatization can weaken the social support needed from the family during the treatment process and also the social support received by family members from the environment. Stigmatization may have a dynamic role in family system. Differences were reported in the experiences of family members who experienced stigmatizing attitudes and various coping methods were reported (Moses 2014). Interacting with other families, social support within the family, real information about the illness and research findings that form a biological basis about the illness were reported to be the leading sources of power in coping with stigmatization (Wahl and Harman 1989, cited from Wahl 1999). It can be understood that social and internalized stigma decreases the life quality of both patients and patient relatives. Considering its negative effects on patients and families, it can be seen that there is a need to fight stigmatization individually and socially.

Stigmatization in Terms of Time and Societies

Social and internalized stigma can change over time in relation to psychosocial variables. In a study in which the ten-year change of social stigma in the population was tracked in terms of psychopathological characteristics (Pescosolido et al. 2010), it was found that social stigma, social distance and perceived danger increased against individuals diagnosed with alcohol addiction and major depression. In studies psychiatrists and other physicians, general practitioners, nurses, medical faculty students and nursing students participated in, studies conducted in Turkey in the last ten years on stigmatization were analyzed. It was stated that there were no significant changes in attitudes towards mental illnesses in the last ten years and that rejecting and excluding attitudes continued (Arkan et al. 2011). Difficulties of change were observed in attitudes and behaviors related with stigmatization.

Results related with the presence of different ways and different levels of stigmatization were obtained according to the characteristics of societies. In the USA, the nature, direction and magnitude of changes in stigma for mental illness among the general population were examined in a 22-year-long study. Conditions that met the diagnostic criteria for schizophrenia, depression and alcohol addiction were created. It was reported that there were significant decreases in stigmatization towards depression illnesses in the general population over time, while this result was not found in schizophrenia and alcohol addiction (Pescosolido et al. 2021). In one study covering some European countries, information about mental illnesses based on biological models was provided in the context of fighting stigma and professional help was provided. However, no significant difference was found in mental illness related attitudes (Schomerus et al. 2012). In another study, social stigmatization was reported to be common in the USA (Parcesepe and Cabassa 2013). In another study which included a study group of 1229 individuals from 14 European countries, levels of self-perception, stigma and perceived discrimination were examined in patients followed with a diagnosis of schizophrenia and other psychotic disorders. With different levels in different countries, 41.7% internalized stigma and 69.4% perceived discrimination were found (Brohan et al. 2010). In another study covering 27 countries, in face-to-face interviews made with 732 participants who had mental illness experience; it was found that 64% of the participants felt the need to conceal their diagnosis while applying for a job or education, 55% concealed while looking for a close relationship and 72% felt the need to conceal due to discrimination. Levels of intentional and unintentional discrimination levels were found to be consistently high across countries (Thornicroft et al. 2009). In studies conducted on stigmatization in the last decade on groups consisting of healthcare professionals, rejecting and exclusionary attitude was shown (Arkan et al. 2011). It was concluded that stigmatization is a global problem, it varies according to the characteristics of societies and the results may change from culture to culture.

The Relationship Between Stigmatization and Mental Health Services

Attitudes towards schizophrenia were examined in a study group consisting of 290 students attending the faculty of health sciences. Approximately half of the participants were found to have stigmatizing attitudes towards schizophrenia patients (Alpan et al. 2018). In a study including 283 participants, social stigma attitudes of healthcare professionals towards schizophrenia patients and obsessive-compulsive disorder (OCD) patients were compared and evaluated for both patient groups. It was found that schizophrenia patients were more exposed to stigmatization than OCD patients. It was stated that knowing about the diagnosis of cases contributed to a decrease in the social stigmatization level of OCD patients, but not schizophrenia patients (Saad et al. 2022). In a study including a total of 1535 participants (Spain 34,2%; Portugal 30,3%; Italy 52.2%) working in a total of 25 mental health centres (hospital staff 27,2%; other staff 60%) in Spain, Portugal and Italy, attitudes of healthcare professionals towards mental illnesses were examined. Participants were found to have high levels of attitude in general. Psychologists, social service experts, rehabilitation technicians and social educators were found to have high level of positive attitudes, while nurses and some non-clinical staff were found to have partly low level of positive attitudes in some attitudes (Del Olmo-Romero et al. 2019). In a study examining the attitudes of psychiatrists and other physicians towards patients with bipolar disorder, a total of 514 participants, 67 psychiatrists, 156 family physicians and 297 physicians from other branches were included. The results showed that family physicians and physicians of other branches felt less comfortable than psychiatrists while working with patients diagnosed with bipolar disorder (Kılıncel and Ay 2021). In a study conducted in the United States of America on stigmatization, it was reported that some specialists may make decisions contrary to diagnosis and treatment standards in the provision of primary healthcare; there may be errors in the evaluation of symptoms between physical illnesses and mental illnesses; and there may be beliefs that the patient may not adhere to treatment (Corrigan et al. 2014). In a study examining the prevalence of bias towards mental illnesses and the correlation between bias and mental illnesses in healthcare professionals, 3006 participants who used health services previously were included. It was reported that 10.9% of the participants stated that healthcare professionals were biased against them and 62,4% of the 10.9% group had a mental illness (Marchand et al. 2016). In a study examining the stereotype, bias and discrimination towards the stigmatization of mothers who experienced fetal alcohol spectrum disorder and their children who were developmentally affected by this disorder, the themes of immature, lazy, incompatible and socially unskilful were determined for children, while the themes of abusive, denying, discreet and ignorant were determined for their biological mothers. It was found that discriminating attitudes of healthcare professionals had a negative effect on the use of mental healthcare services by mothers experiencing fetal alcohol spectrum disorder and their children (Corrigan et al. 2019).

Social stigmatization prevented many people from starting a mental illness related treatment in the USA (Parcesepe and Cabassa 2013). It was reported that between the years 2002 and 2011, the rate of using mental healthcare services increased in USA soldiers who had posttraumatic stress disorder and major depressive

disorder and in those who did not; while more than half of the soldiers who had mental health problems did not get treatment for stigmatization and stigmatization continued to be a common problem (Phillip et al. 2014). In a study conducted in Korea, the participants were grouped as 18-39 years of age, 40-59 years of age and 60-74 years of age from a study group of 3055 individuals. It was reported that when compared with the other two groups, 60-74 years of age group perceived mental illness related stigmatization more and this situation affected using mental health services more negatively (Park et al. 2015). The results of a study which included 24881 participants from 28 European countries showed that dominant cultural beliefs and individuals' beliefs affected using mental health services negatively and search for treatment of mental illnesses in societies where stigmatizing beliefs were dominant was limited (Bracke et al. 2019). Feelings of incompetence, self-loathing and not using healthcare services due to focusing on the fear of stigmatization were reported as the consequences of social stigmatization (Rüsch et al. 2005). In a retrospective study including 188 participants who had a mental illness but did not start treatment, it was found that lack of information, bias and discrimination related with stigmatization affected the behaviors of seeking for help and recognizing self negatively (Schomerus et al. 2019). In a study examining the psychosocial effects of stigmatization which included 229 participants receiving psychiatric treatment, it was stated that stigmatization was correlated with schizophrenia diagnosis, treatment process of inpatients and experiences such as being mocked and bullied (Świtaj et al. 2019).

The effects of common belief systems about stigmatization in the society on the person in need of treatment and the behavior of giving up receiving psychological help were observed through social relations (Angermeyer et al. 1999). In a study group consisting of 25 nurses working in a psychiatry clinic, evaluations on stigmatization towards schizophrenia patients and suggestions regarding the fight with stigmatization were analyzed in a qualitative study. The results showed that the process of stigmatization started after diagnosis and schizophrenia patients could not make equal use of healthcare services due to stigmatization (Ceylan and Koçak Uyaroğlu 2018). In another qualitative study including a study group of 53 participants making use of mental health services who were living in the rural area and who had low level of income, preferred characteristics of mental health care providers were examined to help in coping with stigma. Fear and shame were determined as themes of how participants perceived their experiences about mental health; pretending and role play were determined as themes for attitudes considered to cause stigmatization and negative judgement about the possible negative consequences of seeking help for a mental illness and being perceived as weak were determined as themes for negative consequences of seeking for help for a mental illness. Being non-judgemental and being an active listener have been stated as the most preferred characteristics of individuals providing mental health services (Crumb et al. 2019). Mental healthcare providers and those making use of these services may be affected by stigmatization in different ways. It can be understood that stigmatization is correlated with decreased chance of success in the treatment and decreased application to treatment.

Discussion

It has been observed that stigma reduces the probability of recovery in mental illnesses (Çam and Çuhadar 2011). Some people who receive treatment experience discrimination and there are social prejudices against these individuals. For these reasons, it has been stated that there is a need to develop methods to fight individual and social stigma (Corrigan and Rao 2012). One of the effective methods of fighting the undesirable consequences of the illness is activities aimed at preventing mental illnesses. These activities aim to increase the effects caused by the illness and to prevent the development of comorbidity, to strengthen functional attitudes and behaviors and to increase social support (Gültekin 2010). Fighting stigma can be considered within the scope of activities aimed to prevent the development of secondary mental illnesses.

Stigmatization behaviors are seen in both the public and also among mental healthcare professionals and they are among the primary problems of mental health services (McCarthy et al. 2009). Healthcare professionals (Corrigan et al. 2014, Marchand et al. 2016, Corrigan et al. 2019, Kılıncel and Ay 2021, Saad et al. 2022) and specialists in mental health services (Henderson et al. 2014, Crumb et al. 2019) may show negative emotional and behavioural reactions towards patients. It has also been stated that stigmatization tendencies of physicians are associated with social attitude and these attitudes have negative effects on individuals' making use of mental health services (Yüksel and Taşkın 2005). Suggestions were made to organize training to decrease the stigma-related attitudes of medical and nursing students for mental illnesses in their professional education (Arkan et al. 2011). Trainings for family, society and healthcare professionals may contribute to fight against stigma (Ceylan and Koçak Uyaroğlu 2018). Within the context of fighting stigma, structured group activities can be developed for healthcare professionals in our country.

The public should be informed to reduce social stigma (Parcesepe and Cabassa 2013). It has been found that using marketing techniques to promote social change reduces stigma, internalized stigma and being exposed to

discrimination related with mental health among public (Thornicroft et al. 2016). In a study using theatre activities to decrease stigma for mental illnesses, it was found that theatre activities contributed to sharing life experiences related with bias and discrimination, reducing social distance and developing interpersonal relationships (Yotis et al. 2017). It was recommended for mental healthcare providers to discuss the impact of stigma on mental healthcare services in public places (Angermeyer et al. 1999). It may be considered to develop culturally approved ways and alternative interventions to fight the negative cultural perspective towards stigmatization and mental illnesses (Rue and Xie 2009). Studies can be conducted to examine the relationships between our cultural characteristics and mental illness-related stigmatization processes.

It has been anticipated that well-designed anti-stigmatization interventions can reduce negative outcomes. In this context, three main strategies consisting of struggle, education and relationship have been put forward (Rüsch et al. 2005). It has been stated that an easy method such as teaching school children the risks of getting drug from the medicine cabinet without permission may be an easy and effective way to make mental illnesses acceptable in general and to be the part of normal culture, and interventions that include the general population may help avoiding the development of stigmatization (Goodman and Scott 2012). New studies conducted on the topic can develop intervention programs that include the general population.

Education and interpersonal relationships are protective factors against social stigmatization (Buizza et al. 2017). In a psychoeducation program discussing perspectives on mental health, decreases were found in stigmatization, while increases were found in flexibility and coping skills (Dobson et al. 2019). Psychoeducation and interaction strategies are reported to decrease negative beliefs related with stigma (Gürbüz et al. 2020). Understanding alcohol addiction and major depression in terms of neuroscience may decrease social stigmatization and increase the possibility of support for treatment (Pescosolido et al. 2010). It has also been stated that cognitive behaviourist group therapy decreases mental health related stigmatization and contributes to the process of complying with the treatment (Tong et al. 2019). There is a need for studies conducted on fighting stereotype, bias and discrimination related with stigma Türkiye. It can be considered to develop structured group activities and psychoeducation programs according to cognitive behaviourist therapy in new studies.

The need for sensitivity of specialists has been emphasized to understand the concern related with stigmatization while talking to patients and their families about the potential risks of the illness (Bhangoo and Carter 2009). Discussing the needs in treatment plan is less stigmatizing and promotes more active participation of patients and families in the treatment process (Rue and Xie 2009). It is thought that there is a need for studies which show the practices in treatment processes which contribute to preventing the possible stigma experiences of patients and to contribute to coping with stigma.

Interventions have been proposed to increase the self-esteem of individuals with mental illness with measures such as laws to prevent discrimination about mental illnesses (Thornicroft et al. 2009). It has been reported that a cognitive behaviourist program which aims for the low self-esteem of individuals between the ages of 18 and 24 who have stigma experiences about mental illnesses contribute to recovery in self-esteem (Langford et al. 2022). It can be recommended to research the relationship between stigmatization and self-esteem, to develop structured group activities to increase self-esteem related with stigma.

When family members do not have sufficient information about the illness, they may experience concerns about uncertainty. Limited information, uncertainty and concerns may feed the overprotective behaviors of the family. Restricted behaviors which are not directed towards the needs of patients may contribute to decrease in self-confidence of patients and to the development of internalized stigmatization. It may be useful to examine the patient's family in addition to the patient in studies on stigmatization.

Common experiences of individuals and groups with biopsychosocially different characteristics decrease bias related with mental illnesses and increase empathy towards individuals with stigmatization risk (Thornicroft et al. 2016). Better empathy and communicative skills have a protective role against stigmatization (Solmi et al. 2020). Studies can be conducted to develop structured group activities aiming to contribute to interpersonal relationship and communicative skills to fight stigmatization against mental illnesses.

It has been suggested to examine the relationship between personality and self-stigma and how these concepts affect the behavior of seeking for treatment (Ingram et al. 2016). Individuals who get psychosocial help in close relationships with patients receiving mental health treatment have been reported to show different attitudes depending on the characteristics of individuals around them and that there is a need to research the mechanisms underlying these differences (Yuan et al. 2018). Researching the relationship between personality traits and

stigmatization can contribute to related literature. Studies showing the relationships between stigmatization and personality traits can be conducted.

Conclusion

Stigma makes it difficult to provide effective mental healthcare service (Ingram et al. 2016). Studies conducted in different societies have shown similar results about the harms of stigmatization and researchers have included many suggestions. It can be seen that individuals who receive psychosocial help are likely to encounter stigmatizing attitudes and behaviors. As can be seen in the results of studies, there is a need for effective fight against stigma. Studies conducted on the topic will contribute to mental healthcare services and social life.

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