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Review Article

Enablers of Mental Illness Stigma: A Scoping Review of Individual Perceptions

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Introduction. Stigma is noted to be one of the greatest barriers to the recovery of persons with mental health problems. Stigma has been acknowledged as both an individual and a social orchestration that has an overpowering impact on the social standing of marginalized persons in a society. This study examined the extant literature to ascertain if any evidence(s) suggested a relationship between perceived public attitudes, religious and cultural beliefs, and structural violence in perpetuating stigma against persons with mental illness. *Method*. We applied a five-step scoping review framework by Arksey and O'Malley to examine evidence in the literature that suggests relationships between perceptions, religious and cultural beliefs, and structural violence in perpetuating stigma. The researchers systematically conducted a literature search from six databases, including CINAHL, Ovid MEDLINE(R), ProQuest Dissertations & Theses Global, Sociology Collection, PsycINFO, and Sociological Abstracts, using search terms that included stigma, mental illness, perception, religious and cultural beliefs, and structural violence. *Results*. An initial search in six databases yielded 1223 articles. Checking in the Google Search engine yielded 30 more articles. After removing 25 duplicates, 1198 articles remained for title and abstract screening. After a full-text review, 1143 articles were removed. Overall, 30 articles were selected for data extraction. Thematic analysis of the extracted data resulted in three main themes. These include perceptions about mental illness, perceptions about stigma and discrimination, and forms of stigma perception. *Conclusion*. This study revealed that individual perceptions of public attitudes contributed to their construction of stigma. It is incumbent on everyone to play their part in mitigating all the negative outcomes that stigma brings, especially to persons with mental illness.

1. Introduction

Stigma is characterized by five interrelated negative attributes of labeling, stereotyping, separation (of "us" and "them"), status loss, and discrimination that is underpinned by power relational difficulties between the powerful who see themselves as normal compared to the stigmatized [1].

In certain jurisdictions, stigmatizing behaviors and attitudes have been linked to the long-term influences of historical traditions underpinned by the people's religious and cultural belief systems [2]. The lives of some people with mental illness (PWMI) are worsened by religious and cultural belief systems that inherently legitimize and justify the unequal social positioning of these persons with the illness. Stigma leads to public labeling, group stereotypes, prejudices, loss of social status and self-worth, and negative implications for social relationships [3] and overall health and well-being.

Aside from stigma and its sequela, recent documentation points to the influences of religious, cultural, and structural violence perspectives of the public towards persons that society perceive as different, including individuals with mental health problems [4]. We argue that these factors impact perceptions of PWMIs in relation to the intrapersonal,

interpersonal, institutional, and systemic mechanisms that underpin the distribution of power and resource disparities across the lines of gender, economic and social class, individual health status, and group identity. These social inequities ultimately lead to structural violence (social and psychological harms that result in permanent disability or death).

The factors that comprise the root causes of stigma and the perpetuation of social and health inequities towards marginalized populations appear diverse, complex, interdependent, and dynamic (continuously changing). According to the National Academies of Sciences, Engineering, and Medicine [5], the root cause of health inequity is the unequal allocation of power and resources that relates to the social determinants of health in terms of goods, services, and societal attention, which manifest as unequal social, economic, and environmental.

Ran et al. [6] reviewed forty-one studies regarding the stigma of mental illness and cultural factors in the community. The researchers found that the social stigma attached to mental illness was high in the Pacific Rim region. Cultural factors (including collectivism, familism, religion, and supernatural beliefs) contribute to societal stigmatizing behaviors and attitudes towards persons with mental illness, their relatives, and mental health professionals. Similarly, Misra et al. [7] conducted a systematic review of the cultural aspects of mental illness stigma among three racial and ethnic minority groups (i.e., Asian Americans, Black Americans, and Latinx Americans) from 1990 to 2019. In this review, the researchers found that racialized and ethnic minority groups expressed higher public and self-stigma than White American groups. The study identified structural stigma in the form of service barriers regarding access and quality problems and affiliative (associative) stigma experiences that led to familial stigma and subsequent concealment of a relative's illness. Misra et al. identified a lack of knowledge about mental illness, cultural beliefs, and negative emotional responses as influential across societies. Therefore, interventions targeting negative cultural perspectives may reduce stigma and service barriers while empowering equity-deserving persons to resist stigma at both interpersonal and personal levels.

Our initial gleaning of the extant literature gave us indications that there was a paucity of empirical research evidence on the subject matter. Even though there is substantial evidence of general research on stigma, to our knowledge, no empirical research globally maps unique concepts such as religious, cultural beliefs, and structural violence perspectives on stigma and mental illness. This scoping review examines and synthesizes the extant literature to ascertain if there is any evidence(s) in the literature that suggests a relationship between perceived public attitudes (individual perceptions), religious and cultural beliefs, and structural violence in perpetuating stigma against persons with mental illness.

2. Materials and Methods

Scoping review processes assist the researcher in analytically reinterpreting the existing literature. Religious and cultural beliefs and structural violence perspectives vis-à-vis stigma are gaining grounds in mental health. We undertook this scoping review to examine the empirical literature to ascertain the extent of research activity regarding the chosen concepts and to identify gaps in the literature. The scoping review method allowed the researchers to incorporate various studies, summarize empirical data to address the research question(s), and generate and disseminate findings to inform future research [8]. In the current review, we applied a five-step scoping review framework by Arksey and O'Malley [8]. The steps include (1) identification of research question(s), (2) identification of relevant studies, (3) selection of included studies, (4) data extraction, charting, and summarization, and (5) data collating, summarizing, and reporting of results.

2.1. Step 1: Identification of Research Questions. Before starting the search for relevant studies, the primary author submitted the research questions to the other coauthors with various expertise in the subject area for vetting and approval. The review addressed the overarching research question: is there empirical evidence suggesting a relationship between perception, religious and cultural beliefs, and structural violence in perpetuating stigma against persons with mental illness? Specifically, the study sought to address the following three subquestions:

(a) What does the extant literature say about the relationships between individual perceptions, religious and cultural beliefs, and mental illness stigma?

(b) Is there any evidence about the relationship between structural violence and mental illness stigma?

(c) What is the evidence about the relationship between religious and cultural beliefs and structural violence?

2.2. Step 2: Identification of Relevant Studies. With the assistance of a librarian, the researcher initially identified search terms and their synonyms for all key concepts of the study topic. Search terms were modified for each database before the search began. The researchers widely and systematically conducted literature searches from six databases including CINAHL, Ovid MEDLINE(R), ProQuest Dissertations & Theses Global, Sociology Collection, PsycINFO, and Sociological Abstracts. The keywords and their synonyms that were used in the search include the following: Stigma *(Attitudes to Mental Illness, Stereotyping, Prejudice, Discrimination, self-stigma, internalized stigma, social stigma, structural stigma, institutional stigma, associative stigma, stigma by association, family stigma health professional stigma)*, Mental illness *(Mental Disorders, Psychiatric Disorder, Mental Patients, Mentally Challenged, Psychiatric Patients, persons with mental illness, people with mental illness)*, Perception (*knowledge, attitude, awareness, social perception, individual perception*), religious and cultural beliefs (*Beliefs, Religious beliefs, Religious and cultural beliefs, Culture, Religion, Cultural beliefs, Practices)*, and Structural violence *(Violence, Institutional violence, Social injustice).*

During the literature search, we "exploded" some key terms in the MEDLINE and PsycINFO databases to direct the system to search for the given key terms and all other

Table 1: Key concepts and their definitions.

Concept	Definition
Stigma	An undesirable and discrediting attribute that disqualifies one from full social acceptance that motivate efforts by the stigmatized individual to hide the "mark" as much as possible [9]
Mental illness	A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning [10]
Perception	The organization, identification, and interpretation of sensory information to represent and understand the presented information, or the environment one lives in [11]
Religious beliefs	A collection of belief systems, cultural systems, and worldviews that relate humanity to spirituality (one's innate character in relation to human existence) and sometimes to moral values; the system of values or principles of uprightness [12]
Cultural beliefs	That which encompass the behavior patterns and lifestyle of society that is made up of shared symbols, artefacts, beliefs, values, and attitudes; that culture is expressed in rituals, customs, and laws and is perpetuated and reflected in sayings, legions, literature, art, diet, costume, religion, making preferences, child upbringing, entertainment, recreation, philosophical thought, and governance [13]
Structural violence	Social arrangements that systematically bring subordinate and disadvantaged groups of persons into maltreatment, further placing them in danger for various forms of suffering [14]

Table 2: Summary of study inclusion criteria.

Population	People with mental illness aged 18 and above
Concept	The study must include "public perception," "mental illness," stigma, "religious beliefs," "cultural beliefs," "structural violence," and/or their synonyms
Context	Global studies that cover various settings (including schools, communities, hospitals or clinics, places of worship, and workplaces) regardless of the country of study
Date of publication	Published studies from 2009 to 2023
Source of research evidence	Peer-reviewed, full-text empirical studies including primary research, qualitative, quantitative, or mixed methods (published and unpublished thesis)
Languages	Full-text papers that have been published in English

more specific terms linked to the original term. Where applicable, we enter the search terms step by step with Boolean search operators (OR and AND) to appropriately broaden or narrow the search results. Where appropriate, Medical Subject Headings (MeSH) terms were used in the search process to optimize results. See an exemplar search strategy in the appendix for details.

We also conducted a manual search on Google to ensure that the review process was thorough. Peer-reviewed, full-text empirical studies, including primary research, qualitative, quantitative, or mixed methods that were published in both health and nonhealthcare databases from January 01, 2009, to May 31, 2023, were included in the review. An initial search in the six databases yielded 1223 articles. Again, checking in the Google Search engine yielded 30 more additional articles. After removing 25 duplicates, 1198 articles remained for the next steps of title and abstract screening. Table 1 shows the six main concepts and their definitions of how we have conceptualized them in relation to the current review.

2.2.1. Inclusion Criteria. A study was included in the review if it met the following criteria: (1) involved a population of people with mental illness (such as schizophrenia and related disorders and mood/affective disorders, e.g., depression and bipolar disorders, substance-related disorders, and anxiety disorders), (2) people with mental illness aged 18 and above, (3) included some or all these terms "public perception," "mental illness," stigma, "religious beliefs," "cultural beliefs," "structural violence," and/or their synonyms, (4) was conducted anywhere in the world, (5) primary research, (6) published since 2009, and (7) published in English.

We excluded studies that had (i) populations other than people with mental illness, (ii) participants under 18 years, (iii) articles published outside the stated publication date and in different languages other than English, and (iv) abstracts only. Table 2 details the set criteria for including papers in the study.

2.3. Step 3: Selection of Included Studies. Having removed duplicates from the initial search results, two researchers, GS and JA, independently checked the titles and abstracts of the papers in line with the set inclusion criteria. After the title and abstract screening of the 1198 articles, the two researchers met and reconciled any discrepancies that each identified before arriving at the final set of articles for full-text review. Finally, the researchers agreed to remove 1143 articles based on various reasons, including papers with non-patient populations, participants under 18 years, articles

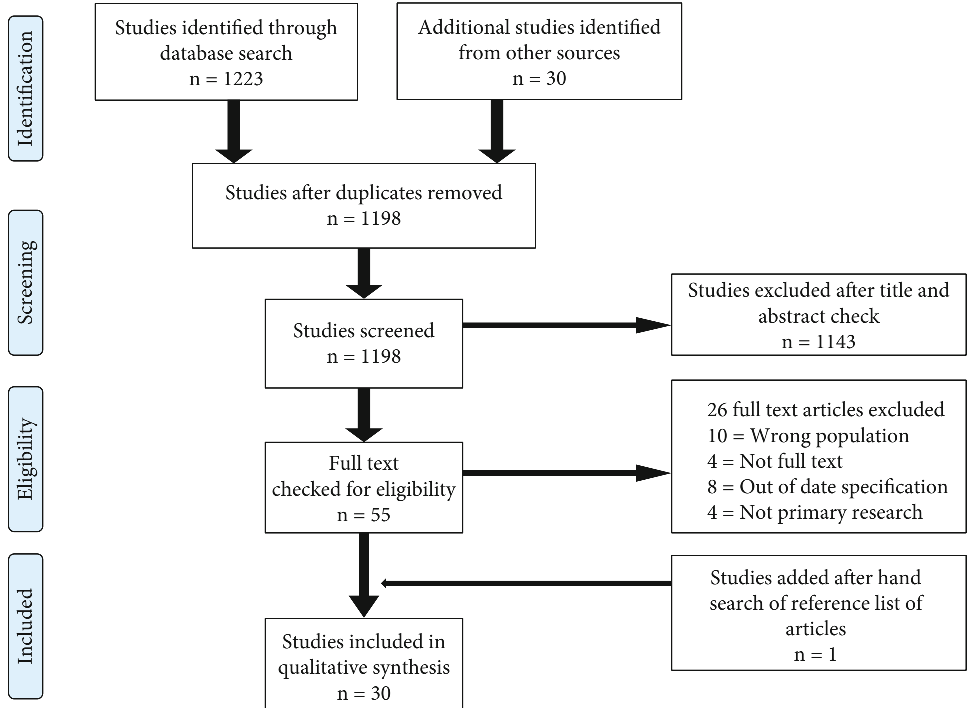

Figure 1: PRISMA flow diagram mapping out the review process.

published before 2009, and in different languages, not full text, and participants' a diagnosis that did not meet the inclusion criteria of the current review. The two researchers further conducted a full-text review of the remaining 55 articles independently, after which they met and resolved any conflicts related to the final set of articles each of them had chosen for data extraction. After the full-text review, 26 articles were eliminated, leaving 29 articles for data extraction. Of the 26 excluded papers, 10 involved a wrong population, 4 were not full text, 8 were out of date specification, and 4 were not primary research (i.e., 2 = opinion papers; 2 = systematic reviews). A manual search of the reference list of the selected articles yielded one more article. We manually searched the included studies to ensure that all possible articles related to the research question were identified. Therefore, the final list of articles selected for data extraction was 30. At the data charting stage, only one researcher, GS, performed all data extraction procedures for the included papers with input from the rest of the research team. See Figure 1 for details of the article selection process as presented in the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) flow diagram [15].

2.4. Step 4: Data Extraction/Charting and Summarization. Before commencing data extraction, we first created a Microsoft spreadsheet with the following subheadings: study number (#), author(s), publication year, country and title, objectives/hypotheses, study design, population (sample size and characteristics), measurements, and main results. This helped us to organize our data and to aid subsequent summarization of the results. Table 3 summarizes the extracted study data.

2.5. Step 5: Data Collating, Summarizing, and Reporting of Results. This step entailed reporting the extracted evidence from the 30 included studies. Having identified the appropriate studies from the various databases, we extracted data from the selected articles that met our set criteria. We then performed thematic content analysis on the extracted data drawing on Braun and Clarke [46] framework. SG (the primary author) read through the initial data for familiarization. Upon a second reading, the investigator initiated open coding (developing and modifying codes along the process). The coded text was reduced by listing all keywords or ideas on a separate Microsoft sheet, after which all codes were defined into common groups (categories) and subcategories (themes). The analyzed data was subsequently presented to the rest of the study team for review and validation. The emerging themes were integrated with their accompanying text and then summarized into a narrative report. In all, three major themes emerged. Any use of direct quotes from the primary studies to support the themes?

Consider stage 6: consultation exercise.

3. Results

3.1. Characteristics of the Included Studies. Considering the year and number of publications, the review identified 30 studies that were published from 2009 to 2023 and includes 2009 = 3 (10.71%); 2010 = 1 (3.57%); 2011 = 3 (10.00%); 2012 = 2 (6.67%); 2013 = 4 (13.33%); 2014 = 6 (20.00%); 2015 = 3(10.00%); 2016 = 2 (6.67%); 2017 = 1 (3.33%); 2018 = 1 (3.33%); 2019 = 2 (6.67%); 2021 = 1 (6.67%); and 2022 = 1 (3.33%).

Table 3: Summary of study results.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
1	Assefa et al., 2012 [16]	Ethiopia (Internalized stigma among patients with schizophrenia in Ethiopia: a cross-sectional facility-based study)	Determine correlates of internalized stigma among outpatients with schizophrenia in Ethiopia	Quantitative (cross-sectional) survey	Data were collected from 212 outpatients aged over 18, who were mostly single (71.2%), unemployed (70.3%), and male (65.1%)	Outpatients with schizophrenia were recruited and assessed using an Amharic version of the Internalized Stigma of Mental Illness (ISMI) Scale	Nearly all participants (97.4%) expressed agreement with at least one stigma item contained in the ISMI. They reported high internalized stigma. Persons who discontinued their treatment reported that they had done so because of perceived stigma, perceived discrimination, alienation, and stereotype endorsement, leading to social withdrawal. Caregiver stigmata (formal and informal) were also common. There was evidence of an association between a history of suicide attempts and high internalized stigma score
2	Barke et al., 2011 [17]	Ghana (The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views)	To examine attitudes of patients and the public towards mentally illness in Ghana	Quantitative (cross-sectional) study	A convenience sample of 403 participants aged over 18 (210 men, mean age 32.4 ± 12.3 years) from urban regions in Accra, Cape Coast, and Pantang answered the Perceived Stigma and Discrimination Scale. 105 patients (75 were men, mean age 35.9 ± 11.0 years).	Researcher-administered interviews were carried out using the Community Attitude towards the Mentally Ill (CAMI) Scale. Perceived stigma was measured with the Perceived Devaluation and Discrimination (PDD) Scale	Patients reported high levels of stigma with secrecy. Perceived discrimination and devaluation Perceived stigma was high. The public regarded PWMI as inferior. The public will not accept them as close friends and will not hire them due to perceptions that they were unintelligent and not trustworthy. Their opinions were also not taken seriously by the community. The participants used concealment to cope
3	Bifftu et al., 2015 [18]	Ethiopia (Perceived stigma and associated factors among people with epilepsy at Gondar University Hospital, Northwest Ethiopia: A cross-sectional institution-based study)	To assess the prevalence of perceived stigma and associated factors among people with epilepsy attending the outpatient department in Ethiopia	Quantitative (cross-sectional) study	408 outpatients with epilepsy. The participants were selected using a systematic random sampling technique. All were aged more than 18 years	Face-to-face interviews were done using semistructured questionnaire. Perceived stigma was measured using the modified Family Interview Schedule (FIS). Beck Depression Inventory (BDI-II) was used to assess depression. The Perceived Stress Scale was used to measure the perception of stress	Overall, the prevalence of perceived stigma was found to be 71.6%. Marital status (single (AOR = 0.23, CI: 0.25, 0.90), widowed (AOR = 0.37, CI: 0.15, 0.90)), duration of illness (2-5 years (AOR = 4.38, CI: 1.98, 9.62), 6-10 years (AOR = 4.29, CI: 1.90, 9.64), ≥11 years (AOR = 4.31, CI: 1.84, 10.00)), and seizure frequency (1-11 per year (AOR = 2.34, CI: 2.21, 3.56), ≥1 per month (AOR = 5.63, CI: 3.42, 10.32)) were all associated with perceived stigma
4	Bifftu & Dachew, 2014 [19]	Ethiopia (Perceived Stigma and Associated Factors among People with Schizophrenia in Addis Ababa.	Assess associated factors of perceived stigma among people with schizophrenia	Quantitative (cross-sectional) study	Sample was select by systematic sampling techniques. 411 outpatients, aged 18 and above, had schizophrenia and were studied using an Amharic version of the Perceived Devaluation and Discrimination (PDD) Scale	Perceived stigma was measured using the Perceived Devaluation and Discrimination (PDD) Scale	The prevalence of perceived stigma was found to be 83.5%. Education status (not able to read and write) (AOR = 2.64, 95% CI: 1.118, 6.227), difficulties of adherence to antipsychotic drug (AOR = 4.49, 95% CI: 2.309, 8.732), and duration of illness less than one year (AOR = 3.48, 95% CI: 2.238, 5.422) were highly associated with perceived stigma Employment status and residence also mediated perceptions of stigma

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
5	Brohan et al., 2011 [20]	13 European countries (Self-stigma, empowerment, and perceived discrimination among people with bipolar disorder or depression in 13 European countries: The GAMIAN–Europe study	Describes the levels of self-stigma, stigma, resistance, empowerment, and perceived discrimination reporting by people diagnosed with bipolar disorder or depression in 13 European countries	Quantitative (cross-sectional) survey	1182 people with bipolar disorder or depression from 13 countries (Belgium, Croatia, Estonia, Finland, Greece, Italy, Lithuania, Macedonia, Malta, Poland, Romania, Spain, Sweden)	Participants completed a mail surveys measuring self-stigma, stigma, resistance, empowerment, and perceived discrimination. The measures included the Internalized Stigma of Mental Illness (ISMI) for self-stigma, the Boston University Empowerment Scale (BUES) for empowerment, and the Perceived Devaluation and Discrimination (PDD) Scale for perceived discrimination	Self-stigma was prevalent. However, there was moderate or high stigma resistance, 63% moderate or high empowerment, and 71.6% moderate or high perceived discrimination. Participants had the lowest scores for the stereotype endorsement subscale. Alienation was the most frequently endorsed subscale (39.3%), followed by social withdrawal (28.7%) and discrimination experience (22.7%). Empowerment, social contact, university education, and employment were all significantly associated with lower self-stigma scores
6	Brohan et al., 2010 [21]	Europe (Self-stigma, empowerment, and perceived discrimination among people with schizophrenia in 14 European countries: The GAMIAN-Europe study	Describes the level of self-stigma, stigma, resistance, empowerment, and perceived discrimination reported by mental health service users with a diagnosis of schizophrenia or other psychotic disorder across 14 European countries	Quantitative (cross-sectional) study	1229 people with schizophrenia in 14 European countries (Bulgaria, Croatia, Czech Republic, Estonia, Greece, Lithuania, Macedonia, Poland, Romania, Russia, Slovenia, Spain, Turkey, Ukraine site A)	Participants completed a mail survey measuring self-stigma, stigma resistance, empowerment, and perceived discrimination levels. The measures included ISMI for self-stigma, Boston University Empowerment Scale (BUES) for empowerment, and PDD for perceived discrimination	Self-stigma was predominant Participants had the lowest scores for the stereotype endorsement subscale. Alienation was the most frequently endorsed subscale (39.3%), followed by social withdrawal (28.7%) and discrimination experience (22.7%). Empowerment, social contact, university education, and employment were all significantly associated with lower self-stigma scores
7	Brouwers et al., 2016 [22]	35 countries (Discrimination in the workplace, reported by people with major depressive disorder: a cross-sectional study in 35 countries	Assess if (1) people with MDD anticipate and experience discrimination when trying to find or keep paid employment	Quantitative (cross-sectional) study	Participants purposively sampled ($N = 834$) were over 18 years. Diagnosis of MDD in the past 12 months from 35 countries. Twenty-five patients were recruited from each site. About half of the participants were married or cohabiting. Two-thirds were women	Participants were interviewed face to face using the Discrimination and Stigma Scale (DISC-12). Internalized stigma was measured with the Internalized Stigma of Mental Illness (ISMI) Scale to assess the subjective experience of stigma	About 63% of participants had anticipated and experienced discrimination in the work setting. Almost 60% of respondents had stopped themselves from applying for work, education, or training because of anticipated discrimination. Participants in countries with a very high HDI reported significantly more anticipated ($\chi^2 = 26.01$ (df = 2), $p < 0.01$) and more experienced ($\chi^2 = 7.25$ (df = 2), $p < 0.05$) discrimination than participants in countries with moderate/low HDI
8	Dako-Gyeke and Asumang, 2013 [23]	Ghana (Stigmatization and Discrimination Experiences of Persons with Mental Illness: Insights from a Qualitative Study in Southern Ghana)	Find out how PWMIs are stigmatized and discriminated against by family members, public (friends and neighbors), employers, and work colleagues	Qualitative study (phenomenology)	Purposive sampling of 10 persons with mental illness aged 18 years, eight PWMI had never married. Two were divorced. The PWMIs were unemployed. Majority of the respondents were Christians and belonged to different ethnic groups	In-depth interviews using unstructured open-ended questions	Findings showed that stigmatization and discrimination during interaction with own family members, association with friends and community members, and contact with employers and work colleagues were common. Social distance and withdrawal from the affected family member were common. Some PWMIs were ignored or neglected by their fathers on grounds that the illness was coming from the mother's lineage. They no more share common space such as the same bed or eating together. Close friends and partners deserted them; some neighbors ridiculed them. Some participants became unemployed due to the inability to find or keep their jobs despite being competent. Employers described them as incapable to work

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
9	Farrelly et al., 2014 [24]	2014 UK (experienced discrimination among people with schizophrenia, bipolar disorder, and major depressive disorder: A cross-sectional study)	Establish associations of anticipated and experienced discrimination among people with schizophrenia and comparators (bipolar and major depressive disorders)	Quantitative (cross-sectional) study	202 individuals with mental illness aged over 18 were studied. 55% were female and 54% were White, while 62% were unemployed. All had some form of education. About 63% of the participants were single Diagnosis from notes indicated bipolar disorder (20.3%), depression (32.2%), and schizophrenia spectrum (47.5%)	Researchers used instruments that include Discrimination and Stigma Scale (DISC), Questionnaire on Anticipated Discrimination (QUAD), Brief Psychiatric Rating Scale (BPRS), Global Assessment of Functioning (GAF), Beck Hopelessness Scale (BHS), Internalized Stigma of Mental Illness (ISMI) Scale, and Multigroup Ethnic Identity (MEIM) Scale	93% of the sample anticipated discrimination and 87.6% of participants had experienced discrimination in at least one area of life in the previous year (employment, friends, dating, neighborhood, housing, transport, family, education, benefits, religion, and physical health). There was a significant association between the anticipation and the experience of discrimination. Higher levels of experienced discrimination were reported by those of mixed ethnicity and those with higher levels of education. Women anticipated more discrimination than men. Neither diagnosis nor levels of functioning were associated with the extent of discrimination. Clinical symptoms of anxiety, depression, and suspiciousness were associated with more experienced and anticipated discrimination. Females anticipated more discrimination in housing (mean difference (MD) = 0.25, $p = 0.04$), education (MD = 0.35, $p = 0.003$), family (MD = 0.31, $p = 0.03$), employment (MD = 0.37, $p = 0.002$), and physical healthcare (MD = 0.33, $p = 0.007$) than males
10	Ghanean and Jacobsson, 2013 [25]	2013 Iran (Internalized stigma of mental illness in Tehran, Iran	To investigate experiences of internalized stigma in mentally ill persons in Tehran, Iran, using the Internalized Stigma of Mental Illness (ISMI) Scale	Quantitative (cross-sectional) study	About 138 outpatients with affective and schizophrenia spectrum disorders. 60% were males and the majority had high school diploma. Mean age of the participants was 30 years. About 79% were unemployed. More females (55%) were married	The Internalized Stigma of Mental Illness (ISMI) Questionnaire was used to measure internalized stigma	About 56% of participants agreed with the statement "having a mental illness has spoiled my life." Few agreed with the statement "stereotypes about the mentally ill apply to me" (38%) and "mentally ill people tend to be violent" (38%) and "mentally ill people should not get married" (33%). Some also experienced discrimination; for example, 53% agreed with the statement "people discriminate against me because I have a mental illness." Others (46%) also withdrew by avoiding social situations to protect their family or friends from embarrassment. A few (30%) agreed that they could have "a good fulfilling life" and "be able to live my life the way I want to"
11	González-Sanguino et al., 2022 [26]	Spain (Mental Illness Stigma. A Comparative Cross-sectional Study of Social Stigma, Internalized Stigma and Self-esteem)	To investigate relationships between social stigma, internalized stigma, and self-esteem	Quantitative (cross-sectional) study	Convenient sampling of 255 persons with severe mental illness. (136 males, 119 females). Majority were single (156), married (61), divorced (34), and widowed (4). Most were employed (74), unemployed (71), or disabled (97). Most finished either elementary studies (73), high school (121), or university (53). About 125 had psychosis, bipolar (11), personality disorder (30), depression (32), and anxiety (57)	Rosenberg Self-Esteem (RSE) Scale to measure self-esteem, Attribution Questionnaire-9 (AQ-9) to measure social stigma, and Internalized Stigma of Mental Illness (ISMI) to measure internalized stigma	Internalized stigma and discrimination were very high among persons with severe mental illness. Persons with severe mental illness were also found to demonstrate more stigma resistance. Overall, most participants reported low self-esteem

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
12	Gyamfi et al., 2018 [2]	Ghana (Individual factors that influence experiences and perceptions of stigma and discrimination towards people with mental illness in Ghana)	To examine perceptions of stigma and discrimination and self-stigma in individuals diagnosed with mental illness	Qualitative study	Purposive sampling of 12 participants (9 males, 3 females). Majority were single (8/12), unemployed (8/12), lived with family members or friends (10/12), and endorsed a Christian faith (10/12). The duration of treatment ranged from 8 months to 18 years (mean treatment duration = 4.7 years). Their ages ranged between 18 and 50 (mean age = 29.8). All participants had some form of education	A single investigator interviewed all participants one on one in English	Negative perceptions about stigma and experiences of discrimination were prevalent. Some lost their jobs, close friends, and partners after discharge from hospital. Their opinions were discounted, and decisions were made for them. Some felt isolated and described themselves as "not being human anymore." Self-stigma was also common. Family members and coworkers discriminated against them. Most participants considered or were told that the problem was spiritual and reflected Christian and traditional thinking around spirituality. Some also attributed their illness to God's punishment for previous poor behavior. Many sought support from Christian churches. Those with a traditional view of being cursed or being invaded by evil spirits paid community healers to rid them of the curse or evil spirits. Eventually, all sought hospital care, either on the advice of a close relation or the church. They also attributed social and biological causation to their illness. Some coped by quitting their jobs and concealing their illness, while some moved multiple times to avoid persons who knew about their illness. Others engaged in social withdrawal and self-isolation. Some also prayed
13	Hansson et al., 2014 [27]	Sweden (Perceived and anticipated discrimination in people with mental illness—An interview study)	To investigate perceived discrimination in a sample of users in contact with mental health services in Sweden	Quantitative (cross-sectional) study	156 outpatients were involved. Two-thirds of whom were female. About 55% were living alone, while nearly 74% were unemployed. The two major diagnostic subgroups were anxiety/depression (46.3%) and psychosis (38.5%). The mean number of years since first contact with psychiatric services was 15. Mean number of hospitalizations was five, and around one-third of the participants had been involuntarily hospitalized	Telephone interviews were conducted with 156 outpatients, asking for perceived and anticipated discrimination during the last 2 years. Background characteristics were also collected. The instrument used for the interviews was DISC-12	Perceived discrimination was common. Family and caregiver stigma and discrimination were prevalent, including avoidance by people who knew about the mental illness. Most of those anticipating discrimination regarding job or education seeking or starting a close relationship had no experience of discrimination in these areas. Previous hospitalizations were associated with discrimination and age with anticipated discrimination. Areas with the least perceived discrimination included religious practice, starting a family, and using public transport. Most participants coped by concealing their illness from others. They also stopped themselves from having close personal relationships and from applying for work or education

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
14	Harangozo et al., 2014 [28]	21 countries: Bulgaria, Italy, Hungary, Lithuania, Poland, Romania, UK, Slovakia, India, Slovenia, Cyprus, Finland, France, Germany, Greece, Malaysia, Spain, Netherlands, Norway, Portugal, Switzerland)	To investigate whether people with schizophrenia experience discrimination when using healthcare services	Quantitative (cross-sectional) study	About 777 participants with schizophrenia (62% male and 38% female) from inpatient and outpatient home care and day care	Face-to-face researcher interviews. Data collection related to healthcare, disrespect of mental health staff, personal privacy, safety, and security, starting a family, pregnancy, and childbirth. Discrimination was measured by the Discrimination and Stigma Scale (DISC)	Participants experienced discrimination when treated for physical health problems and at mental health hospitals. They were discriminated against in several life domains related to friendship, treatment by family, keeping a job, travel visas, welfare benefits, and pension and opening a bank account, voting in elections, religious practices, social life, treatment by the police, arranging payment for medical care, and dental treatment. Even home care service patients also felt discriminated against when wanting to start a family. Perceived disrespect was also high
15	Jhon et al.,2021 [29]	Hong Kong (Predictors and outcomes of experienced and anticipated discrimination in patients treated for depression: A 2-year longitudinal study	Investigate predictors of experienced and anticipated discrimination, as well as the impacts of discrimination, on treatment outcomes in patients with depressive disorders receiving pharmacological interventions	Quantitative (longitudinal) study	230 patients with depressive disorders	The Hamilton Rating Scale for Depression, Hospital Anxiety and Depression Scale, Clinical Global Impression Scale-Severity, Social and Occupational Functioning Assessment Scale (SOFAS), EuroQol-5 Dimension (EQ-5D) Questionnaire, and Sheehan Disability Scale were administered to assess various depression outcomes. Baseline personality was evaluated using the Big Five Inventory-10	A history of depression predicted experienced discrimination. Higher levels of education predicted a higher level of anticipated discrimination. A nonmarried status predicted a greater level of anticipated discrimination. Anticipated discrimination was high in those with worse functional impairment. Patients who reported higher levels of experienced discrimination exhibited worse outcomes. Anticipated discrimination score, the male gender, educational level, current nonmarried status, being employed, a previous suicide attempt, the PSS score, HADS-A score, and SDS score were positively associated, whereas age, having religion, a monthly income >2,000 USD, the CDRS score, EQ-5D utility index score, and BFI-K-10 extraversion and agreeableness scores were negatively associated. On multivariable analysis, the years of education, nonmarried status, and disability score at baseline were independently associated with higher-level anticipated discrimination
16	Li et al., 2017 [30]	China (Stigma and discrimination experienced by people with schizophrenia living in the community in Guangzhou, China)	To investigate experienced stigma and discrimination and their associated factors in people with schizophrenia who live in the community in Guangzhou, China	Quantitative (cross-sectional) study	A total of 384 people aged between 18 and 50 with schizophrenia were randomly recruited from four districts of Guangzhou	Participants completed self-reported questionnaires: Internalized Stigma of Mental Illness (ISMI) Scale, Self-Esteem Scale (SES), Discrimination and Stigma Scale (DISC-12), Brief Psychiatric Rating Scale (BPRS), PANSS negative scale, Global Assessment of Functioning (GAF), and Schizophrenia Quality of Life Scale (SQLS)	People with schizophrenia often experience stigma and discrimination in the Chinese population. The public perceived them as dangerous. Participants were avoided or shu by the public Participants concealed their illness. Most of the participants were also unemployed and unmarried

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
17	Lin, 2012 [31]	USA (Beliefs about causes, symptoms, and stigma associated with severe mental illness among 'highly acculturated' Chinese American patients	To examine mental health beliefs among highly acculturated Chinese American patients with severe mental illness and serves to fill the gap in the literature of Chinese American mental health	Qualitative study	About 29 persons aged 20-75 years. Twenty-six participants had high school education. Twenty-two were diagnosed with schizophrenia, schizoaffective disorder, and psychosis not otherwise specified (NOS). Six people were diagnosed with bipolar disorder type I and one person with major depressive disorder recurrent type. They received health services on an average of 13.9 years	Semistructured interviews were conducted based on Kleinman's explanatory model	Causes of mental illness include biological factors, head trauma, and personal loss. About 15 persons believed mental illness is hereditary, from neurotransmitter deficiencies or brain abnormalities, while seven and six participants believed family loss and past negative interpersonal experiences and drug use, respectively caused the illness. Four participants also referred to head trauma as the causative factor. Three participants also cited sexual abuse and psychological trauma. Additionally, two participants believed that their mental illness was caused by improper diet. Public stigma was also common; some neighbors blamed them and described them as a disgrace to their families. However, some participants did not feel ashamed of their illness, and that they were going to go public about their illness to be role models to many who were hiding their illness. Few participants spoke about traditional Chinese medicine when asked about treatment options
18	Lv et al., 2013 [32]	China (Experienced stigma and self-stigma in Chinese patients with schizophrenia)	To investigate experienced stigma and self-stigma in patients with schizophrenia in mainland China. Methods	Quantitative (cross-sectional) study	Nonprobabilistic sampling method was used to recruit 95 outpatients. About 61% were male. Participants' mean age was 26.27 years. About 64% were employed. About 68% were single, married (27%), and divorced (4%). About 68% completed high school. Duration (years) of mental illness, mean ± (S.D) = 4.51 ± 3.87. Family history of mental disorder Yes = 19 (20.0%) No = 73 (76.8%) Hospitalizations below 3 times = 69 (72.6%) and ≥3 times = 26 (27.4%)	Ninety-five patients with schizophrenia completed Chinese versions of two self-report questionnaires: the Internalized Stigma of Mental Illness (ISMI) Scale and the Modified Consumer Experiences. of Stigma Questionnaire (MCESQ). They also completed two other self-report questionnaires: the Social Support Rating Scale (SSRS) and the World Health Organization Quality of Life (WHOQOL-BREF) questionnaire. A senior psychiatrist also assessed patients using the Scale for Assessment of Positive Symptoms (SAPS) and the Scale for Assessment of Negative Symptoms (SANS)	On the ISMI, the percentage of participants who rated themselves above the midpoint of 2.5 (i.e., high level of self-stigma) was 44.2% ($n = 42$) for alienation, 14.7% ($n = 14$) for stereotype endorsement, 25.3% ($n = 24$) for perceived discrimination, 32.6% ($n = 31$) for social withdrawal, and 20.0% ($n = 19$). On the Stigma Questionnaire (MCESQ), the percentage of participants who rated themselves above the midpoint of 3.0 was 24.2% ($n = 23$) for stigma. Socioeconomic factors were related to the severity of psychiatric stigma. Some described themselves as looking strange and their lives as "spoiled," while others concealed their illness from family, friends, and the public
19	Oleniuk et al., 2013 [33]	Canada (The Impact of Stigma of Mental Illness in a Canadian Community: A Survey of Patients Experiences	Examined how willing patients are to share details of their mental illness and to determine if individual characteristics have a role on stigma	Quantitative (cross-sectional) study	41 persons agreed to participate. About 56% were male. About 51% completed a college diploma. Participants were diagnosed with schizophrenia, bipolar depression, and substance abuse. Twelve inpatients had been hospitalized first time, while 29 had one or more hospitalizations. Average length of illness was 19.5 years (SD = 14.4)	Face-to-face interviews assessed opinions on the Experiences with the Stigma of Mental Illness—Consumer Version	Those who attended outpatient sessions, previously hospitalized, or younger suffered more stigma impact. Health professionals were rude and stigmatized them. This impacted recovery negatively because they lost trust in the professionals. Stigma also negatively influenced their health seeking. Participants feared or lost trust in community members. They could not ask for help from them; they felt safer staying away from the public due to the shame their illness brought unto them

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
20	Oshodi et al., 2014 [34]	Nigeria (Pattern of experienced and anticipated discrimination among people with depression in Nigeria: a cross-sectional study.	The study evaluated the impact of stigma and discrimination among. Individuals with major depression in Nigeria	Quantitative (cross-sectional) study	Person with major depression aged over 18. The mean age of the participants was 35.5 years	Face-to-face interviews were conducted with 103 participants using a sociodemographic questionnaire, the Discrimination and Stigma Scale, the Internalized Stigma of Mental Illness Scale, the Boston University Self-Empowerment Scale, and the Rosenberg Self Esteem Scale	Participants were unfairly treated in dating or intimate relationships, while concealment of mental illness was the most common for anticipated discrimination. Younger people (less than 40 years) with higher level of education had a high risk for experienced discrimination. Some also faced unfair treatment at work and therefore withdrew from their job. About 51% coped by making friends with people who did not use mental health services, while 36% used personal capabilities in coping with stigma. The greatest advantage was being positively treated by family (62.1%), followed by positive treatment in religious activities (23.3%). More than half of the respondents concealed their diagnosis from others. Self-esteem and self-efficacy were low. Patients with tertiary education compared with those with secondary or lower level of education showed experienced stigma
21	Quinn et al., 2015 [35]	USA (From Discrimination to Internalized Mental Illness Stigma: The Mediating Roles of Anticipated Discrimination and Anticipated Stigma)	Explored how experiences of discrimination relate to greater anticipation of discrimination, devaluation, and internalized stigma	Quantitative (cross-sectional) study	Participants were 105 adults with mental illness	Using laptops, 105 adults with mental illness self-reported their experiences of discrimination based on their mental illness. The instruments used include the lifetime discrimination scale used in the National Midlife in the United States (MIDUS) and the Berger et al. [36] stigma scale	Experienced discrimination was common and resulted in increased anticipated discrimination, social stigma, and greater internalized stigma. The most common types of discrimination reported were not getting hired for a job (26%), getting hassled by the police (23%), getting fired from a job (16%), and getting poorer medical treatment/services (13%). The degree to which participants anticipated some discriminatory experiences was not influenced by having experienced that event. Participants also reported not getting promoted for a job. They experienced discrimination from healthcare providers as well
22	Quinn & Knifton, 2014 [37]	Uganda (Beliefs, stigma and discrimination associated with mental health problems in Uganda: Implications for theory and practice)	To understand beliefs, stigma, and discrimination associated with mental health in Uganda from the perspectives of different stakeholders	Qualitative study	Purposive sampling of 40 participants, i.e., mental health activists (with lived experience) (they did not describe the sample in detail)	Key informant interviews in English and two focus groups discussions, each with 12 mental health activists in a language they could understand	The public describe every mental health issue as "madness." The public still hold unto traditional cultural explanations for mental illness, such as being possessed by evil spirits, as a punishment or curse. The best way to treat mental illness was to seek traditional treatment or faith cures. They also believed in social and biological causes of mental illness. While the participants stigmatized themselves, family and community members discriminated against them. Participants were also discriminated against by health professionals, employers, and colleagues in the workplace. Negative media reportage was common on TV, radio, and newspapers

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
23	Rüsch et al., 2009 [38]	USA (A Stress-Coping Model of Mental Illness Stigma: I. Predictors of Cognitive Stress Appraisal)	Tested whether the level of perceived public stigma and personal factors such as rejection sensitivity, perceived legitimacy of discrimination, and in-group perceptions predict the cognitive appraisal of stigma as a stressor	Quantitative (cross-sectional) study	85 outpatients with schizophrenia, schizoaffective, or affective disorders participated in the study. Participants' average age was about 45 years ($M = 44.8$, SD = 9.7), and 68% were male. More than half (58%) were African American and a third (34%) Caucasian, while a few reported Hispanic or Latino (5%) and mixed or other ethnicities (4%). On average, participants with mental illness were first diagnosed about 15 years ago ($M = 14.9$, SD = 10.2) and had been hospitalized in psychiatric institutions about nine times ($M = 9.2$, SD = 13.1)	Cognitive appraisal of sexism was used to measure cognitive appraisal of stigma-related stress. The Perceived Devaluation and Discrimination Questionnaire measured the perceived levels of stigma against PWMI. The Adult Rejection Sensitivity Questionnaire measured rejection sensitivity. The Social Cue Recognition Test measured social cognitive deficits that affect stigma perception	Stress appraisal did not differ between diagnostic subgroups but was positively correlated with rejection sensitivity. Higher levels of perceived societal stigma and holding the group of people with mental illness in low regard (low group value) independently predicted high stigma stress appraisal. High group value was related to more perceived resources to cope with stigma. More rejection sensitivity was also associated with higher perceived stigma, stress, and lower perceived coping resources. Group identification and entitativity were positively related to both perceived harm and perceived coping resources. The findings support the model that public and personal factors predict stigma stress appraisal among people with mental illness, independent of diagnosis and clinical symptoms
24	Sanseeha et al., 2009 [39]	Thailand (Illness perspectives of Thais diagnosed with schizophrenia	Explored the perceptions of 18 people diagnosed with schizophrenia from 1–10 years to uncover how they perceived themselves and their illness.	A qualitative, descriptive study that employed in-depth interviews and observations	18 outpatients with schizophrenia were purposively selected. All were over 18 years (24-57 years, mean = 35.6 years). Eight participants were single, six were married, and four were divorced. All were Buddhists. Seven were unemployed, three were employed in government services, and eight were in private employment	Data were collected using in-depth interviews and observations	Participants felt their symptoms including physical, behavioral, cognitive, and emotional aspects were abnormal, chronic, and required continuous medication and treatment. They believed supernatural powers, bad karma from the past, or biological factors caused their symptoms. They blamed themselves for their illness, describing themselves as sinners and living a bad life, that is why they got sick from karma. Participants felt discriminated by society. They were isolated leading to a feeling of shame. They felt disrespected and distrusted and lost their self-confidence. Participants coped through encouraging themselves, seeking social support from relatives, and following "dharma" or Buddhist morality teachings, practicing mindfulness or positive concentration, meditation (detachment), and praying
25	Shrivastava et al., 2011 [40]	India (Origin and Impact of Stigma and Discrimination in Schizophrenia - Patients' Perception: Mumbai Study)	Assessed the perceptions of patients with schizophrenia regarding the stigma and discrimination they face in their lives	Quantitative (cross-sectional) study	Convenience sample of 100 patients (74 males) with schizophrenia, who were attending outpatient psychoeducation in a hospital in Mumbai, India, was surveyed. Their mean age was 39.2 years (SD = 7.9; range 22-58). All participants had a minimum of grade 12 education. They were living with families and belonged to the middle class	Opinions on various aspects of stigma were obtained using a semistructured interview guide developed by a national working group in India by the World Psychiatric Association steering committee	About 69% of the respondents experienced stigma in their personal lives. A lack of knowledge, the nature of the illness, and behavioral symptoms were the main causes of stigma and discrimination. Common effects of stigma were low self-esteem and discrimination in family and work settings. Providing care and treatment was identified as the most common method of combating stigma. The availability of effective treatment was thought to be the most important method of reducing stigma. The prevailing social stigma from family members, coworkers, and health professionals resulted in low self-esteem of participants. Participants also reported problems coping with their marriage and not receiving proposals for marriage due to their illness

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
26	Sun et al., 2019 [41]	Five Asian countries: China, Korea, Malaysia, Singapore, and Thailand (Perception of Stigma and Its Associated Factors Among Patients with Major Depressive Disorder: A Multicenter Survey from an Asian Population)	To examine the level of perceived stigma and its associated factors in MDD patients in five Asian countries, including China, Korea, Malaysia, Singapore, and Thailand	Quantitative (cross-sectional) study	A total of 547 outpatients with MDD were enrolled from mainland China (114 cases), Taiwan (99 cases), Singapore (40 cases), Korea (101 cases), Thailand (103 cases), and Malaysia (90 cases)	Researchers used the Explanatory Model Interview Catalogue (EMIC) to assess stigma and the Montgomery–Asberg Depression Rating Scale (MADRS), Symptoms Checklist 90-Revised (SCL-90-R), Fatigue Severity Scale (FSS), Sheehan Disability Scale (SDS), 36-Item Short-Form Health Survey (SF-36), and Multidimensional Scale of Perceived Social Support (MSPSS) to assess their symptoms, clinical features, functional impairment, health status, and social support	The stigma scores of patients under 55 years old were significantly higher than those equal to or greater than 55 years old ($p < 0.001$). The stigma scores exhibited a significant negative correlation with age and MSPSS scores of family, friends, and others
27	Tawiah et al., 2015 [42]	Ghana (mental health-related stigma and discrimination in Ghana: experiences of patients and their caregivers	To provide evidence on the types of mental health, stigma and discrimination, and challenges, coping, and support strategies used by patients	Quantitative (cross-sectional exploratory) study	Two hundred and seventy-seven patients were selected through simple random sampling and interviewed. About 55% were above 35years. Nearly 62% of the patients were females and 65% were unmarried. Close to 45% were educated, while 93% were Christian	Two research assistants conducted face-to-face interviews using a structured questionnaire with (patients)	More females were stigmatized than males at the work/employment and educational levels. Various forms of stigma were observed at the economic, psychological, and social levels, while for discrimination, it was only observed at the economic and social levels. Caregivers were also stigmatized and discriminated. The coping strategies adopted by the patients and their caregivers were also economic, psychological, and social in nature. The main reported cause of mental disorder was biological (45%), while 32% reported spiritual causes and curses. The preferred treatment of mental disorders was biomedical (79%) and faith based (18%)
28	Thornicroft et al., 2009 [43]	Global (Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey)	To describe the nature, direction, and severity of anticipated and experienced discrimination reported by people with schizophrenia in 27 countries	Quantitative study	732 outpatients with schizophrenia	Face-to-face interviews with 732 participants with schizophrenia	Rates of experienced discrimination were high and consistent across countries. Negative discrimination was experienced by 344 (47%) of 729 participants in making or keeping friends, by 315 (43%) of 728 in family members, by 209 (29%) of 724 in the finding job, by 215 (29%) of 730 in keeping a job, and by 196 (27%) of 724 in intimate or sexual relationships. Positive experienced discrimination was rare. Anticipated discrimination affected 469 (64%) in applying for work, training, or education and 402 (55%) looking for a close relationship; 526 (72%) felt the need to conceal their diagnosis. Over a third of participants anticipated discrimination for job seeking and close personal relationships when no discrimination was experienced. Rates of both anticipated and experienced discrimination were high across countries among PWMI

Table 3: Continued.

#	Author(s), publication year	Country and title	Objectives/hypotheses	Study design	Population (sample size and characteristics)	Measurements	Main results
29	Van Horn, 2019 [44]	United States (The influence of structural stigma on mental illness: State level structural stigma and attitudes towards treatment seeking and quality of life)	The influence of structural stigma on mental illness in relation to attitudes towards treatment seeking and quality of life	Quantitative (structural equation modelling)	787 adults with mental illness, aged 18 years or older. Majority of the sample was female (511 (64.86%)), employed (412 (52.33%)), White 554 ((70.39%)), and married or cohabitating with a partner (466 (59.15%))	Participants completed the scales and questionnaires: Satisfaction with Life Scale (SWLS), Attitudes toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-S), Perceived Devaluation and Discrimination Scale (PDD), Community Attitudes towards the Mentally Ill (CAMI), and ISMI	Higher levels of structural stigma were associated with lower quality of life ($b = -0.121$, $p = 0.024$). Higher levels of structural stigma were significantly associated with more negative attitudes regarding treating the mentally ill in communities ($b = 0.736$, $p = 0.006$). Higher levels of experienced stigma negatively influence attitudes towards treatment seeking. Higher levels of self- stigma negatively influenced attitudes toward seeking treatment. Individuals with higher levels of public stigma also had higher levels of experienced stigma ($b = 0.057$, $p = 0.012$)
30	Ye Chen et al., 2016 [45]	Australia (Stigma and discrimination experienced by people living with severe and persistent mental illness in assertive community treatment settings)	Describe perceived experiences of stigma and discrimination among PWMI in assertive community treatment (ACT team) settings in New South Wales, Australia	Quantitative (cross-sectional) study	Fifty clients with schizophrenia or schizoaffective disorder aged 18 and above participated. Majority of participants were male (72%) with a median age of 52 years (range = 40 – 58), a primary diagnosis of schizophrenia (86%), or schizoaffective disorder (14%)	The Discrimination and Stigma Scale (DISC) was used to explore and measure negative, anticipated, and positive discrimination levels. Face-to-face interviews were conducted	Participants experienced negative discrimination and unfair treatment including being avoided or shunned by neighbors and family. Participants were denied employment and even volunteering, once they disclosed their illness. These experiences impacted self-esteem and perception of self-stigma of participants. Participants also experienced discrimination from healthcare professionals when seeking physical healthcare, including lack of respect and perceived as less intelligent irrespective of education level. Some also anticipated discrimination in relationships that was not linked to experienced discrimination. Participants overcame stigma through music, meditation, writing, avoidance, and acceptance of one's illness

In terms of country and the number of studies, we observed that among the 30 included studies, 25 were conducted in only one country In contrast, five (5) were conducted in multiple countries and in multiple sites. The single country research sites include Thailand [39], Uganda [37], Ghana [2, 17, 23, 42], United States of America (USA) [31, 35, 38, 44], Canada [33], China [30, 32], Nigeria [34], Australia [45], Ethiopia [16, 18, 19], United Kingdom (UK) [24], India [40], Sweden [27], Iran [25], Spain [26], and Hong Kong [29]. Aside from the two studies [25, 44] that a single researcher conducted, two or more researchers conducted the rest of the included studies.

In relation to the included studies that were conducted in multicountry/multisites, the following five (5) studies were identified: Brohan et al. [20], 13 European countries, i.e., Belgium, Croatia, Estonia, Finland, Greece, Italy, Lithuania, Macedonia, Malta, Poland, Romania, Spain, and Sweden; Brohan et al. [20], 14 European countries, i.e., Bulgaria, Croatia, Czech Republic, Estonia, Greece, Lithuania, Macedonia, Poland, Romania, Russia, Slovenia, Spain, Turkey, and Ukraine; Thornicroft et al. [43], 27 countries involving European, Asian, and North and South American, i.e., Spain, India, Poland, Greece, Malaysia, Germany, Tajikistan, the UK, Canada, Belgium, Italy, Switzerland, Netherlands, Austria, Norway, Slovenia, Lithuania, Bulgaria, Slovakia, Portugal, Romania, Turkey, Cyprus, Finland, France, the USA, and Brazil; Harangozo et al. [28], 21 countries including Bulgaria, Hungary, Lithuania, Poland, Romania, Slovakia, Slovenia, Cyprus, Finland, France, Germany, Greece, India, Italy, Malaysia Netherlands, Norway, Portugal, Spain, Switzerland, and the UK; Brouwers et al. [22], 35 countries involving Belgium, Bulgaria, England, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, Netherlands, Portugal, Romania, Scotland, Slovakia, Slovenia, Spain, Turkey, Australia, Brazil, Canada, Croatia, Czech Republic, Egypt, India, Japan, Malaysia, Morocco, Nigeria, Pakistan, Serbia, Sri Lanka, Taiwan, Tunisia, and Venezuela; and Sun et al. [41], five countries involving China, Korea, Malaysia, Singapore, and Thailand.

With regard to the area(s) of focus of the 30 studies, nine studies focused on perceptions (beliefs) of stigma and discrimination associated with mental illness [2, 18, 19, 27, 37, 38, 40, 41, 45], while four studies each examined internalized stigma [16, 25, 26, 35] and severity of anticipated and experienced discrimination [22, 24, 29, 43], respectively.

In another vein, two studies each concentrated on three areas. These include patient attitudes and perceptions about mental illness [17, 39], experienced stigma [30, 32], and stigma resistance and empowerment [20, 21]. The remaining research areas had one study each concentrating on them. These include how persons with mental illness were stigmatized and discriminated against [23], experienced discrimination [28], impact of stigma and discrimination [34], coping with stigma and support strategies [42], and influences of structural stigma on mental illness in relation to attitudes towards treatment seeking and quality of life [44].

About 25 (83.33%) of the studies used quantitative cross-sectional designs with self-reported questionnaires, while only 5 (16.67%) of the articles used qualitative methods with in-depth one-on-one interviews to study participants. The overall population of participants involved in the 30 studies was 9554. All 30 studies recruited both males and females. While 4675 (49.35%) were male, 4799 (50.65%) were female. Only one (0.01%) participant reported being transgender. We, however, note that 68 (0.75%), i.e., 18, 10, and 40 participants from Thailand, Ghana, and Uganda, respectively, did not indicate their gender. The total number of married or cohabitated participants was 2338 (25.78%). The rest were either single, divorced, separated, or widowed.

Regarding participant education and employment, 6335 (69.85%) had some form of education from primary to university. In comparison, 3038 (33.50%) of the participants had some form of job, including full-time, part-time, and volunteer work. The remaining participants were either retired, unemployed, or students. Out of the 30 studies, only 6 (20%) reported on the religious denomination of their participants. Participants' diagnoses as indicated by the various studies included schizophrenia spectrum disorders, 3110 (34.39%); mood/affective disorders, 3331 (36.73%); neuropsychiatric disorder, 427 (4.71); substance use disorders, 34 (0.43%); anxiety disorders, 81 (0.89%); adult attention-deficit/hyperactivity disorder (0.154%); eating disorder, 7 (0.08%); and personality disorder (0.03%). A few participants, however, failed to indicate their diagnosis.

4. Study Themes

The current review examined factors that contribute to the perpetuation of mental illness stigma among persons with mental illness globally. Thematic content analysis of the 30 included studies resulted in three main themes. These include (1) perceptions about mental illness, (2) perceptions about stigma and discrimination, and (3) forms of stigma perception (see Table 4 for details).

4.1. Perceptions about Mental Illness. Perception influences awareness and ways of thinking (opinion formation) concerning environmental issues [47, 48]. Such long-standing opinions may lead to the development of societal belief systems, attitudes, values, norms, and behavioral patterns. In relation to the current review, six of the included studies discussed how persons with mental health problems view their illness vis-à-vis public interactions [2, 31, 37, 39, 40, 42]. The subthemes related to perceptions about mental illness include the nature of illness, perceived etiology/causality, and the nature of treatment modalities for mental illness.

4.1.1. Perceived Nature of Illness. Three studies [31, 37, 39] presented evidence on how some individuals described their illness. Some persons with mental illness felt that their symptoms were abnormal. Some common symptoms among participants increased their awareness of a potential mental illness. For instance, a Thai study by Sanseeha et al. [39] found that most PWMIs were usually aware of their symptoms. Participants felt that their symptoms including physical, behavioral, cognitive, and emotional aspects were abnormal. They believed the abnormality was a chronic condition [31, 37, 39] and required continuous medication and

Table 4: Summary of study themes.

Major theme	Subtheme
Perceptions about mental illness	Perceived nature of illness Perceived etiology/causality Nature of treatment modalities
Perceptions about stigma and discrimination	Labeling and stereotyping Prejudice Public discrimination Rejection sensitivity
Forms of stigma perception	Family-orchestrated stigma and discrimination Structural/institutional stigma and discrimination Health professional stigma Associative stigma Internalized/self-stigma

treatment [39]. In Sanseeha et al.'s study, it came out that even though some participants believed that their drugs helped alleviate the symptoms, they still felt they might not fully recover. Some openly said they expected to relapse and did not believe they would recover. In another vein, some participants disclosed that members of the public believed that mental illness is contagious (emphasizing epilepsy), inheritable (going from generation to generation), and chronic (that PWMIs do not recover from the illness). This belief limited some participants' life chances, for example, in marriage [37].

4.1.2. Perceived Etiology/Causality. Perceptions about the causes of mental illness were varied. Six studies [2, 31, 37, 39, 40, 42] identified some perceived causes of mental illnesses among PWMI. These factors included biological, psychosocial, trauma, and religious, cultural, and traditional beliefs.

Some participants believed biological factors contribute to mental illness [31, 39, 42]. Some of these biological factors include head trauma and neurotransmitter deficiencies through brain abnormalities [31], complications from drug use [31, 40], improper diet [31], and genetic inheritance [31, 39]. Some patient participants disclosed that their relatives told them that their illness was passed on to them by their ancestors (grandparents through genetics) [31, 39].

Psychological stress and social distress were cited as key causes of mental illnesses. Perceptions (beliefs) about the causes of mental illness have been diverse. Some PWMI attributed their illness to negative personal losses including marital or family problems or other family losses [31]. Others have cited the psychological trauma associated with the sexual abuse they experienced as a precursor to their illness [31]. Several participants attributed the cause of mental illness to distress, anxiety, and an overactive mind [31, 37, 39]. Some participants also mentioned poverty and loss of job as a cause of mental illness due to the distress associated with not being able to care for themselves and their family in terms of food, education, or even transport to the hospital to seek healthcare [37]. A social causation was also mentioned. For instance, a few attributed their illness to specific events, such as the breakup of an intimate relationship [2, 37].

While some people had no idea about the cause of their illness [42], others expressed the conviction of what they think caused mental illness. Participants believed that the causes of their illness were supernatural powers such as black magic, bad karma from the past, evil spirits from ancestors, and demons [2, 39, 42]. Supernatural power (use of black magic) is believed to affect one's psychological or mental behaviors, including emotions, to deviate from normality. The participants believed this happened, especially if someone disliked you or envied you for your success at work. Most participants mentioned that the public still holds onto supernatural and traditional cultural explanations for mental illness, such as being possessed by evil spirits, as a punishment or curse due to wrongdoing. They also believed that mental illness occurs due to curses, witchcraft, or when clan spirits or social spirits get angry with someone [37, 39]. Most participants considered or were told that the problem was spiritual and reflected Christian and traditional thinking around spirituality. Some also attributed their illness to God's punishment for previous poor behavior [2, 42].

4.1.3. Nature of Treatment Modalities. Despite evidence of people seeking orthodox treatment, the influences of tradition and faith in treatment modalities were pervasive among some studies, mostly from the LMICs. Four studies, including Gyamfi et al. [2], Lin [31], Quinn and Knifton [37], and Tawiah et al. [42], discovered some modes of treatment that PWMI sought in their community. There is no doubt that one's belief system impacts their treatment choices. For some of the participants, the best way of dealing with such problems was to seek traditional treatments or faith "cures" from faith healers, including pastors [2, 31, 37, 42], imams, fetish priests, and herbal medicine practitioners [37]. For instance, a Ugandan study by Quinn and Knifton [37] underscored that traditional beliefs often coexist with social, biomedical, and religious explanations regarding cause and treatment seeking. For many participants in Christian and Muslim communities, mental health problems had a religious cause attributed to sin or the "will of God." Many sought help from their Christian churches [2, 31, 37, 42]. Those with a traditional view of being cursed or invaded

by evil spirits paid community healers to rid them of the curse or evil spirit [2, 37]. Eventually, all sought orthodox or hospital care, either on the advice of a close relation or the church.

4.2. Perceptions about Stigma and Discrimination. Public (social) stigma is widespread with associated negative attitudes from society. All 30 included studies [2, 16–35, 37–45] reported on how persons with mental illness appraise public attitudes towards them. This evidence of stigmatization and discrimination was mostly observed during interactions with family members, friends and community members, health professionals, and during contact with employers and work colleagues. Under this theme, we identified four subthemes: labeling and stereotyping, prejudice, public discrimination, and rejection sensitivity.

4.2.1. Labeling and Stereotyping. Eleven out of the 30 included studies reported on labeling and stereotyping. The 11 studies included Assefa et al. [16], Bifftu and Dachew [19], Dako-Gyeke and Asumang [23], Ghanean and Jacobsson [25], Gyamfi et al. [2], Li et al. [30], Lin [31], Lv et al. [32], Quinn and Knifton [37], Sanseeha et al. [39], and Shrivastava et al. [40]. The participants spoke about self-labeling, public labeling, and media labeling.

Regarding self-labeling and stereotyping, some persons described their symptoms as unpredictable, while others described themselves as violent [25]. For instance, in Thailand, participants described their symptoms as "pheekuow' in Thai, meaning possessed, uncontrollable situation [39]. In Ethiopia, Bifftu and Dachew [19] also found that most participants stereotyped themselves by agreeing with public perceptions that PWMIs are dangerous and unpredictable. Some described themselves as looking strange and that their life was "spoiled" [32].

In relation to public or social labeling and stereotyping behaviors, some individuals reported public tagging attitudes in various jurisdictions. Some felt branded by neighbors through their actions [31]. A section of the public described PWMI as different [39]. The public described them as "phee-bha" in Thai (meaning, insane). In certain jurisdictions, the public described every mental health issue as "madness" [2, 37]. Others describe them as "mad" [2, 23]. Public perceptions of dangerousness [30, 37], unpredictability [23, 37], and being described as funny were also pervasive in society [2, 37]. Some members of the public also described PWMI as crazy [2, 23] and violent [23]; as such, they would be scared and careful when dealing with them [23].

The media also promoted negative publicity (media stereotyping) by using derogatory tags in describing PWMI. This largely contributed to the discrimination and subsequent stigma that some PWMI faced [2, 40]. Such public perceptions of dangerousness created social distance, isolation, and withdrawal, leading to a communication gap between people with mental health problems and the rest of society.

4.2.2. Prejudice. Four studies of 30 articles mentioned negative and unjustified public attitudes towards individuals with mental illness [31, 37, 39, 40]. Most PWMIs were rejected several times [39, 40]. The public distrusted them due to their illness [39]. PWMIs were also blamed for their illness [31, 37]. Participants heard offensive comments from family and neighbors alike [40]. Some family members described their sick relatives as a disgrace to the family [31]. The continued public branding and judgment increased perceived public (social) stigmatizing attitudes and shame associated with having a mental illness. In some jurisdictions, the public believed that patients might have committed a serious crime or sin that led to their predicament. These misperceptions were linked to religious and traditional cultural beliefs/explanations upheld by the public [37]. The members of the public also perceived the patients as "figures of pity" needing sympathy and special consideration [37].

4.2.3. Public Discrimination. Some participants experienced unfair treatment from others based on their illness. Out of the 30 studies, twenty-one of them identified discrimination from the public as a key factor that contributes to perceptions of stigma among PWMI [2, 16, 17, 20–22, 24, 25, 27–30, 32, 34, 35, 37, 39, 40, 42, 43, 45]. In some cultures, shame, guilt, embarrassment, and loss of respect (for individuals and family) are powerful factors shaping and influencing how people feel and respond to stigma and discrimination. Rates of discrimination in society, both anticipated and experienced discrimination, were consistently high across countries [2, 17, 20–22, 24, 27–30, 34, 35, 39, 40, 42, 43, 45]. One of the most frequent items for experienced discrimination was being unfairly treated in dating or intimate relationships [2, 34, 40, 43], or being avoided or shunned by neighbors and family [27, 30, 37, 45].

In another vein, some of the included studies involved [2, 17, 20–22, 24, 27, 29, 30, 34, 35, 39, 40, 42, 43, 45] identified anticipated discrimination as a key factor that affects the life aspirations of some PWMI. Both experienced discrimination and anticipated discrimination were widespread. For instance, Brouwers et al. [22] studied participants with major depression in 35 countries. Most of these participants encountered experienced and anticipated discrimination in the work setting. In highly developed countries, nearly 60% of respondents stopped applying for work, education, or training because of anticipated discrimination. Participants in countries with a very high Human Development Index (HDI) (i.e., higher standard of living) reported more anticipated and experienced discrimination than those with moderate or low HDI. However, two studies [43, 45] reported a lack of negative treatment, otherwise known as *positive discrimination*, among some participants who received various forms of special support from the public.

4.2.4. Rejection Sensitivity. Rejection sensitivity is a psychological response characterized by chronic anxious expectations of rejection that PWMI portray during social interactions. Rejection sensitivity is a coping method for some people to guard against potential threats in their social

environments [49]. Only two out of the 30 included studies reported on rejection sensitivity among PWMI [2, 38]. Stigma and discrimination are not experienced equally by PWMI [37, 38]. Such differences may be due to existing public prejudice [2], higher levels of perceived societal stigma stress appraisal among PWMI [38], and high level of experienced discrimination [2, 22, 24, 27, 28, 30, 34, 35, 39, 40, 42, 43, 45].

4.3. Forms of Stigma Perception. Stigma and discrimination are not experienced equally [37, 38]. Stigma and discrimination are also experienced or perceived differently depending on who and what is involved in the process. In the current review, 15 of the included studies [2, 16, 22, 23, 26–28, 30, 34, 35, 37, 40, 41, 44, 45] identified various ways in which stigma was portrayed among PWMI. The five subthemes under "forms of stigma perception" include family-orchestrated stigma and discrimination, structural/institutional stigma and discrimination, health professional stigma, associative stigma, and internalized/self-stigma.

4.3.1. Family-Orchestrated Stigma and Discrimination. People with mental illness experience stigma and discrimination in various forms by their family members. Some participants bemoaned the attitude of some family members as disturbing and regarded as the most common source of discrimination and stigma distress towards PWMI. Eight studies out of 30 [2, 16, 23, 27, 28, 37, 40, 41] reported on this phenomenon. Some participants claimed their families blamed them for causing their illness [23, 37]. Some relatives also accused participants of falling sick because they associated themselves with bad friends [23], while some family members believed the sick relatives had sinned or offended some spirits and, therefore, their ancestors were punishing them for this [2, 23, 37]. Some studies also reported on how families abused the human rights of their sick relatives. For instance, the impending shame of having a relative with mental illness made some members distance themselves by hiding, separating, or locking them away from social interactions [23, 37]. Similarly, some individuals revealed that their partners deserted them and sought new companions [23]. Even though perceived family stigma and discrimination were evident, some studies, including Hansson et al. [27] and Shrivastava et al. [40], found low stigmatizing attitudes from some extended family members towards PWMI in marital life, including when trying to raise their own family.

4.3.2. Structural/Institutional Stigma and Discrimination. Institutional discrimination constitutes practices and policies within organizations (formal or informal) that systematically culminate in denying PWMI access to existing resources and opportunities. The participants (patients) observed various incidents of discrimination in their workplaces by employers and employees alike. Nine studies reported that discrimination against PWMI was widespread in the workplace [2, 22, 30, 34, 35, 37, 40, 44, 45]. PWMI had been denied employment and even volunteered once they disclosed their illness [37, 44, 45]. Negative media reportage about people with mental illness is common in certain jurisdictions, contributing to creating and perpetuating unfair institutional or organizational policies. Two studies [2, 37] reported the influence of media pronouncements that contributed to the phenomenon.

4.3.3. Health Professional Stigma. Health professionals also contributed to the stigma process in several ways. There have been several reported cases of experienced discrimination during treatment seeking for PWMI in both physical and mental healthcare settings globally. Nine of the included studies reported on the behavior of health professionals towards PWMI [2, 16, 21, 27, 28, 33, 35, 40, 45]. For instance, some patients reported how their doctors and nurses disrespected and looked down on them by refusing to tell them what was wrong when they wanted an explanation for their illness. These behaviors from health professionals contributed to the low health-seeking behaviors among PWMI [2, 33, 37]. According to Brohan et al. [21], a lack of knowledge about one's illness predisposes the individual to self-stigma than those who become aware of and accept their illness. Health professionals were also rude [33] and disrespected their clients [28, 45]. Some professionals perceived individuals with mental illness as less intelligent, irrespective of their education level [45]. Despite the negative report on health professional behavior, two included studies [28, 45] spoke positively in terms of the support that some health professionals gave to their clients during treatment seeking.

4.3.4. Associative Stigma. Some family members and health professionals had their fair share of negative public attitudes [50]. For instance, some studies claimed that neighbors gossiped, ridiculed, and always pointed fingers at family caregivers and their children suffering from mental illness. Only two included studies identified this experience [2, 23]. Some families reportedly lost their close friends [23]. This is probably one of the reasons why some families either stay away or keep their sick relatives from the public. In most collectivist societies, community members play a large role in choosing a partner. Due to the prejudice around mental illness, most close family members of PWMI reportedly found it difficult to get partners in their community [2, 23].

4.3.5. Internalized/Self-Stigma. Internalized self-stigma is a self-devaluation process characterized by awareness of public stereotypes, agreeing with them, and applying them to the self [51]. There is a high prevalence of perceived stigma that persons with mental illness usually direct at themselves. In this review, 16 studies reported the existence of internalized self-stigma. The studies include Assefa et al. [16], Bifftu and Dachew [19], Bifftu et al. [18], Brohan et al. [21], Brohan et al. [20], Ghanean and Jacobsson [25], González-Sanguino et al. [26], Gyamfi et al. [2], Hansson et al. [27] Lv et al. [32], Oleniuk et al. [33], Oshodi et al. [34], Quinn et al. [35], Quinn and Knifton [37], Sanseeha et al. [39], and Van Horn [44].

Personal responses to discrimination may occur in several ways, including self- or internalized stigma processes. In the current review, some participants revealed that they lost their self-confidence [26, 39] owing to the pervasive

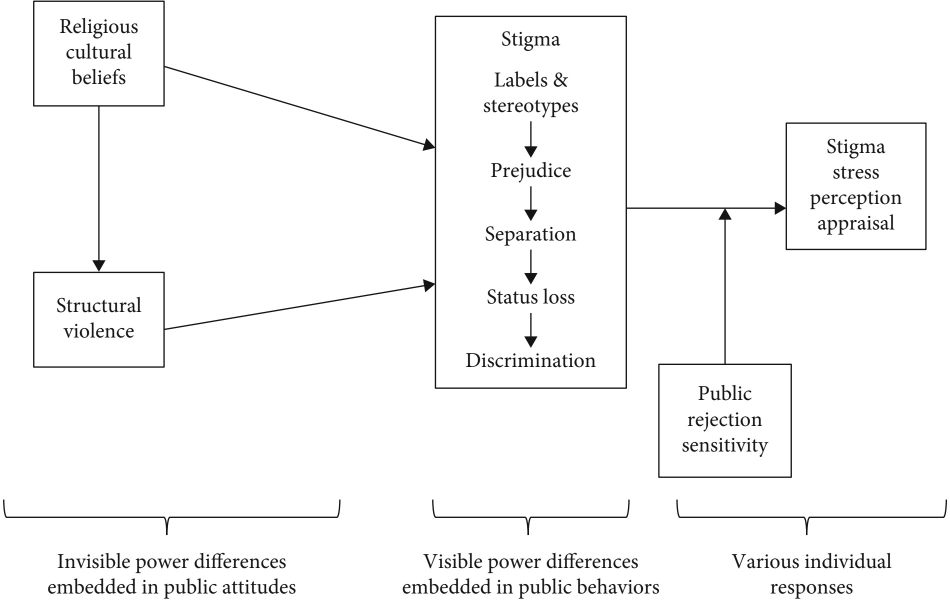

Figure 2: A proposed stigma stress perception appraisal model (SSPAM) of mental illness.

social discrimination, leading to feelings of inferiority [39]. Most PWMI frequently expressed feelings of shame [31, 37], guilt [18, 37], depression [18], feeling of worthlessness [37], and isolation [2]. Persons who experienced self-stigma also experienced some form of alienation, experienced discrimination, or social withdrawal [20]. It is worth noting, however, that some PWMI in some of the studies reported low levels of self-stigma in the presence of high stigma resistance and empowerment. The five studies documenting high stigma resistance include Brohan et al. [21], Brohan et al. [20], González-Sanguino et al. [26] Lin [31], and Oleniuk et al. [33].

5. Proposing a Contemporary Stigma Model

Based on our knowledge of the literature so far, we conceptualize and define stigma as "the product of public attitudes and behaviors that characterize labeling, stereotyping, prejudice, cognitive separation, status loss, and discrimination that lead to responses that may include stress and esteem-related appraisal of experienced, anticipated, perceived or personal endorsement of societal actions that are anchored by existing power relational differentials." (Figure 2) shows the "stigma stress perception appraisal model (SSPAM)" inspired by our new definition of stigma. We believe that religious and cultural belief systems and structural violence perspectives are mostly invisible, powerful tools embedded in social governance structures that create and sustain stigma against vulnerable groups in the form of labels, stereotyping, and prejudice that culminate in a cognitive separation of the "us" versus "them" situation. Once separation (segregation) becomes successful, the vulnerable individuals lose their social status, leading to discrimination. Discriminatory attitudes and behavior from the public lead to coping orientations of rejection sensitivity (a disposition of anxious expectations in which vulnerable persons readily perceive and overreact to social rejection cues). Depending on the extent of rejection sensitivity, the individual may perceive and appraise stigma stress appropriately (as negative or positive) with subsequent impact in their life domain.

6. Discussion

Issues of mental illness, stigma, and discrimination are complex and, therefore, need to be understood in relation to the cultural, social, and economic context of the society in which the affected persons live. Considering this, the current review examined the extant literature to ascertain if there was any evidence suggesting a relationship between perceived public attitudes, religious and cultural beliefs, and structural violence in perpetuating stigma against persons with mental illness.

Perceptions of an individual influence their awareness and opinion formation concerning environmental issues [47, 48]. Such long-standing opinions may lead to developing societal belief systems, attitudes, values, norms, and behavioral patterns.

The review brought to the fore that the perceived influence of religious and cultural beliefs about the causation of mental illness is a well-documented issue, especially among most low- to middle-income countries compared to the high-income ones—revealing a strong underlying influence that traditional faith, including religious and cultural values, plays a significant role in shaping perceptions and attitudes towards vulnerable groups including persons with mental illness [52, 53]. We emphasize, however, that people have varied perceptions about the nature and cause of their illness. For instance, while some studies identified psychosocial and economic factors as mental illness triggers, some acknowledged biomedical including physical and genetic causes. These mixed perceptions also informed the treatment modes that individuals and their families patronized

first when sick. For example, while the European and American studies reported mainly on orthodox treatment, the African and Asian studies reported on the mix of traditional faith healing and orthodox health seeking. Despite the strong attributions of supernatural and traditional bases concerning the incidence of mental illness, the role of biomedical and psychosocial causes was evident in the extant literature of both low- to middle-income and high-income countries. The ideological stance of most Western countries leaning more towards the biomedical model in relation to causality and treatment further explains why none of the participants in the studies conducted in Europe and America referenced supernatural or spiritual causes. Generally, the Western model of mental illness causality and treatment is incongruent with beliefs in supernatural causes. This is probably one of the reasons why most stigma frameworks do not inculcate religious and cultural perspectives to help explain stigma processes linked to mental illness.

Just as has been found in other reviews, findings from our study confirmed that public stigma and discrimination were widespread with a consequential negative overall effect on PWMI and their close associates, including family members, friends, community members, health professionals, and during contact with employers and work colleagues [54–56]. The review again confirmed the existing literature that even though most PWMI experienced various forms of stigma, the nature of one's illness in relation to behavioral symptoms contributed to the social stigma and discrimination they encountered [57]. The participants' stigma perceptions included family stigma and discrimination, structural/institutional stigma and discrimination, health professional stigma, associative stigma, and internalized/self-stigma. Overall, individuals with higher levels of public stigma were likely to have higher levels of experienced stigma [58].

The review highlights evidence of labeling and stereotyping, prejudice, public discrimination, and rejection sensitivity in relation to stigma and discrimination from the public. These negative attitudes and behaviors were mostly observed during interactions with family members, friends, community members, health professionals, employers, and work colleagues. As found in our study, the consequence of stigma and discrimination usually takes various forms including economic, social, and psychological effects, leading to negative outcomes of social separation (distancing or exclusion) and status loss due to perceived devaluation from society relating to the individual's incapacity.

According to Link and Phelan [1], mental illness stigma could be explained by five co-occurring components: labeling, stereotyping, separation, status loss, and discrimination. Link and Phelan further contend that labeling or tagging comes from a social process of categorization that are underpinned by power differences. Elsewhere, Corrigan et al. [59] have also argued that labels such as "dangerous," "violent," and "unpredictable" entrench stereotyping behaviors and pave the way for discrimination and other sequels of stigma to occur. Once the individual applies these stereotypes to the self, they internalize and experience self-stigma, leading to negative implications that include self-esteem problems, social withdrawal, joblessness, partner loss, and low quality of life.

7. Implications

More than a decade ago, some authorities, including Corrigan [60] and Kelly [61, 62], argued that mental illness stigma was an issue of injustice that culminated in the harm or death of persons experiencing mental health problems and, as such, called for action towards ameliorating this predicament. We, therefore, undertook the current review to ascertain whether there is empirical evidence in the literature that suggests a relationship between perception, religious and cultural beliefs, and structural violence in perpetuating stigma against persons with a history of mental illness. Even though the review established substantial evidence of research on stigma as perceived by PWMI, no empirical research globally mapped the unique concepts of structural violence and religious and cultural perspectives on mental illness stigma. This gap has implications for future stigma research. We believe that successful primary research in this area will create avenues for further evidence towards unique interventional studies that would stimulate enhanced social advocacy while streamlining changes in anti-stigma policies and strategies.

8. Limitations

The current scoping review enabled the researchers to systematically search from various databases to reinterpret the existing literature analytically. Again, the scoping review method allowed us to incorporate various study designs and summarize data (including published and grey literature) to address our research questions. Despite these strengths, the review also had limitations. The fact that we limited the age of the study population to 18 years and above excluded other studies that had populations outside this age bracket, leading to the loss of information relating to children and adolescents who experience stigma due to their illness. Future reviews should examine the perspectives of children and adolescents in relation to stigma and its impact on this population. Again, the fact that we restricted the study to articles published in the English language from 2009 to 2023 might have excluded some relevant articles. Even though we consulted with experts who were members of the research team (regarding research question formulation and the analysis process), our inability to undertake consultation with PWMIs might have impacted our findings. Even though the consultation stage is optional [8], it could have further enriched the study findings had it been fully explored to the latter. The impact of this limitation is reduced by the authors' continuous engagement and expertise in the subject matter for a balanced reporting of the findings. That said, it was also relevant that we situated the review within a certain context and time frame of recency to inform future stigma research paths. In all, the effective application of the five-step scoping review framework by Arksey and O'Malley [8] allowed us to address our research questions to generate findings that could be vital to future primary research.

9. Conclusion

The consequence of existing power differentials and the negative public misconception about mental illness is the

inherent basis for the exclusionary attitudes and behaviors that society perpetuates against the PWMI. Interventions that encourage personal empowerment could play a vital role in overcoming the stigma associated with mental illnesses.

The current review identified negative media reportage about mental illness as common in certain jurisdictions on television, radio, and newspapers as reinforcers of negative stereotypes through abusive language and negative labeling. Such sustained negative public views strengthen inequity, making PWMI develop negative attitudes towards themselves and others in their community. Eventually, stigma directed at the self prevents people from seeking help, leading to further complications that fuel more self- and public stigmatizing behaviors.

Appendix

Database: Ovid MEDLINE(R) results on May 31, 2023

Search strategy:

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1 exp Mental Disorders/ or exp Stereotyping/ or exp Social Stigma/ or exp Prejudice/ (1204273)

2 mental illness∗.mp. or exp psychiatric disorder/ or “persons with mental illness” (133656)

3 1 and 2 (61349)

4 belief∗.mp. or “Health Knowledge”, or exp Attitudes, or exp Perception/ or awareness (166741)

5 exp Culture/ or exp cultural (31803)

6 exp Religion/ or "Religion and Culture"/ or “Religious and Cultural (19951)

7 exp Violence/ or “Structural violence” or “Social injustice” or “Institutional violence” (29289)

8 Social Discrimination/ (950)

9 3 or 8 (62228)

10 4 or 5 or 6 (207832)

11 9 and 10 (2811)

12 7 and 11 (42)

Data Availability

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

Conflicts of Interest

The authors want to state that they have no competing interests to declare.

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