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Roadmap to reduce the stigma of mental illness in the Middle East

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INTRODUCTION

Although it has been almost 50 years since Erving Goffman's groundbreaking book defined stigma(1963), inspiring researchers to study this social problem and devise interventions to overcome it, stigma persists in the community. Goffman defined stigma as "the process by which the reaction of others spoils normal identity"(1963). These reactions come from prejudgment of a person based on limited information. Stigma results in labeling, prejudice, stereotyping, separation, status loss, and negative discrimination (Link & Phelan, 2001). It thus prevents many individuals with mental illness from obtaining treatment. Shame and low self-esteem in individuals with mental illness are common by-products of stigma. Societal stigmatization of the mentally ill can be internalized and thus threaten quality of life, disrupt social relationships, and decrease the likelihood that persons with mental illness seek mental health services or obtain employment. Stigma is, therefore, considered a barrier to recovery from mental illness, even for individuals who receive treatment.

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We review the available literature on stigma related to mental illness in the Middle East. First, we discuss mental health services in this region and note how they have changed over time. Next, we present an overview on the stigma related to mental illness and explain how it significantly hinders access to mental health services. Finally, we present our literature review and discuss our findings.

Background

The Middle East region—The Middle East region is defined as “the countries of southwest Asia and North Africa.” We chose this area because of the relative homogeneity of the populations based on religion and culture. Almost 90% of people in this region are Muslims. Islam is considered not only a religion but also a way of life and the most important cultural factor affecting people’s attitudes in this region. The practice of Islam has given people in the Middle East region a common identity in many spiritual beliefs and aspects of day to day living (Mohit, 2001). The other religions commonly practiced in this region are Christianity and Judaism, which share roots with Islam; all three religions possess more similarities than differences at their core (Pridmore & Iqbal, 2004).

Historical overview of mental health services in the Middle East: The Middle East has an illustrious history in the field of mental health services; the first psychiatric hospitals in the world were built in Baghdad in 705 CE, in Cairo in 800 CE and Damascus in 1270 CE (Murad & Gordon, 2002). There are records of esteemed Muslim physicians like al-Razi (d. 925), who wrote a 24-volume encyclopedia of medicine and treated psychiatric patients (Pridmore & Iqbal, 2004). IbnSina (Avicenna; d. 1037), another early Muslim scholar in psychiatric health care wrote ‘The Canon of Medicine’, a the 14-volume tome used in the west for more than 700 years (Pridmore & Iqbal, 2004). On the other hand, popular beliefs in Middle Eastern cultures have traditionally viewed mental illness as a punishment from God, the result of possession by evil spirits (Jinn), the effects of the “evil eye”, or the effects of evil in objects that are transferred into the individual. Scholars like IbnSina did not agree with these supernatural explanations (Pridmore & Iqbal, 2004). The Qalaoon Hospital, established in Cairo during the 14th century, was reputed for a mental illness ward that could care for 8,000 patients. The patients with mental illness were rarely isolated from those with other diseases. The Qalaoon Hospital also had a dispensary and research facility that led to advances in knowledge about mental illnesses (Okasha, 2005).

Current mental health services in the Middle East—Despite the historic importance that the Middle Eastern region had in the care and understanding of mentally ill individuals, the human resources and attention given to mental health issues in the 21st century are insufficient. Although improvements have occurred in mental health services in the Middle East in the past decade, there are still many countries in which health services for this population are below accepted standards. Indeed, only three countries have provided estimates of mental health expenditure as a percentage of total health expenditure: Palestine (2.5%), Qatar (1%), and Egypt (less than 1 %) (Okasha A. et al., 2012). The psychiatrist/ population ratio is another indicator of the status of mental health services; the highest proportion of psychiatrists is reported in Qatar, Bahrain, and Kuwait. Iraq, Libya, Morocco, Sudan, Syria, and Yemen have fewer than 0.5 psychiatrists per 100,000 persons. The number

of psychiatric nurses ranges from 23 per 100,000 population in Bahrain, 22.5/100,000 in the Gulf Emirates, 0.09/ 100,000 in Yemen and is reported as 0.03/ 100,000 in Somalia (Okasha et al., 2012). However, there is some indication of a progressive increase in the number of nurses, as well as social workers, with the most substantial increases reported from Bahrain, Emirates, Jordan, Egypt, Kuwait, Libya, Saudi Arabia and Yemen (Okasha et al., 2012).

Stigma related to mental illness—Stigmatization of mental illness existed well before psychiatry became a formal discipline, but was not formally labeled and defined as a societal problem until the publication of Goffman's book (1963). Mental illnesses are among the most stigmatizing conditions, regardless of the specific psychiatric diagnosis (Corrigan & Lundin, 2000; Corrigan & Penn, 1999; Tringo, 1970; Weiner et al., 1988). Unlike other illnesses, mental illness is still considered by some to be a sign of weakness, as well as a source of shame and disgrace. Many psychiatric patients are concerned about how people will view them if knowledge of their condition becomes public (Rusch et al., 2005).

Stigma is composed of interpersonal or public stigma and intrapersonal or self-stigma. Public stigma has three major components: stereotypes, prejudice, and discrimination (Rusch et al., 2005). Stereotypes are based on knowledge available to members of a group and provide a way to categorize information about other groups in society. Stereotypes quickly generate impressions and expectations about persons belonging to a particular group (Rusch et al., 2005). Prejudiced persons agree with these negative stereotypes, and these attitudes lead to discrimination through negative behaviors toward mentally ill individuals. These negative perceptions create fear of and social distance from mentally ill persons (Corrigan et al., 2000). When individuals endorse these stigmatizing beliefs, they show higher levels of avoidance and refusal to help a person with a psychiatric diagnosis (Corrigan et al., 2003). Although the media can play an important role in improving public understanding of mental illness (Byrne, 2000; 1997), they often misrepresent mentally ill individuals as dangers to society (Farina 1998, Hyler et al., 1991, Wahl, 1995). Self-stigma consists of the same components as public stigma, namely stereotyping, prejudice, and discrimination. Stereotyping occurs when a person internalizes the negative attitudes about mental illnesses, which leads to a negative emotional reaction and low self-esteem (Rusch et al., 2005). Most psychiatric patients experience self-stigma (Corrigan, 2005).

Burden due to stigma—Individuals with mental illness have the dual burden of coping with the symptoms of the mental illness, like hallucinations, depression, delusions, and anxiety, as well as the societal stigmatization of their illness (Rusch et al., 2005). Stigma acts as a barrier to recovery; epidemiological research suggests that more than half of the people who might benefit from mental health services refuse to access them (Narrow, 2000), (Regier, 1993) so as to avoid being labeled as "mentally ill" (Kessler, 2001). Senses of shame, low self-efficacy, and lack of confidence make patients try to avoid stigma by not seeking the required treatment. The negative effects of stigmatizing attitudes toward people with mental illness can influence all life domains : living, learning, working, and establishing friendships (Rusch et al., 2005).

The external effects of public stigma refer mainly to discrimination against people with mental illness in relation to housing, work, and social interactions (Hinshaw & Cicchetti,

2000). In a seminal study, 52% of respondents stated that they experienced discrimination after they received mental health services and 41% indicated they were treated differently all or most of the time after their diagnosis became known to others (Campbell & Schraiber, 1989). When people with psychiatric disorders are exposed to public stigma, they often suffer from self-stigma, including diminishing self-esteem, self-efficacy, and confidence in the future (Corrigan, 1998; Holmes & River, 1998). This self-stigma can have harmful consequences on their quality of life (Graf, et al., 2004). A fear of rejection can have serious negative consequences; e.g., people who have been hospitalized for a mental illness may act less confidently, more defensively, and be more avoidant with others (Link et al., 2001). Low self-efficacy in people with mental illness leads to diminished opportunities to pursue work or independent living that might have otherwise had favorable outcomes (Link, 1982, 1987). Although stigmatizing attitudes are not confined to mental illness, the general public seems to disapprove of persons with psychiatric disabilities more so than of persons with physical deformities or non-psychiatric diseases (Weiner et al., 1988, Socall et al., 1992, Piner et al., 1984). The impact of stigma extends beyond the individuals with mental illness; it also affects their families, who report feeling ashamed of a relative's mental illness (Corrigan & Miller, 2004).

Measures of Stigma—Several scales to measure the existence of stigma in society are available. Some are based on how people consider mental illness and perceive the mentally ill; others measure the attitudes and behavior of the public toward mentally ill individuals. Social distance is the primary measure used to assess a respondent's willingness to interact with a target individual. It was first defined by Robert Park (1924) as “the grades and degrees of understanding and intimacy which characterize pre-social and social relations generally.” The first Social Distance Scale was used for race/ethnicity studies and later applied to mental illness in 1957 (Cumming & Cumming's 1957). The Semantic Differential Scale, developed by Charles E. (1957), is used to estimate stigma by quantifying stereotyping, which can be defined as the tendency to link the label ‘mental illness’ with negative attributes. Strueing and Cohen also developed scales to assess opinions about mental illness (OMI) in 1960 (Strueing & Cohen, 1963).

Brohan and colleagues have classified stigma measures into perceived, experienced, and self-stigma measures. Using this classification, several useful scales are available. The most commonly used measures of perceived stigma include: the Perceived Discrimination Devaluation (PDD), Self-stigma of Mental Illness Scale (SSMIS), Inventory of Stigmatizing Experiences (ISE), Stigmatization Scale (HSS), Self-esteem and Stigma Questionnaire (SESQ), Depression Self-Stigma Scale (DSSS) and Discrimination and Stigma Scale (DISC). Several other scales are commonly used as measures for experienced stigma such as the Internalized Stigma of Mental Illness (ISMI) scale, Stigma subscale of the Consumer Experiences of Stigma Questionnaire (CESQ), Rejection Experiences Scale (RES), DSSS, Self-reported rejection experiences scale (SRE), the Stigma Scale (SS), Inventory of Stigmatizing Experiences (ISE), MacArthur Foundation Midlife Development in the United States (MIDUS), DISC and Experiences of Discrimination (EDS). Self-stigma, which pertains to cognitive, affective, and behavioral responses to perceived or experienced stigma,

has been assessed using measures including: ISMI, SSMIS, DSSS, SS and ISE (Brohan et al., 2010).

In the Middle East region, the Stigma Devaluation Scale 'SDS' was translated into Arabic, modified, and culturally adapted by a translation model. Estimation of internal consistency was used to assess the reliability of the SDS. Construct validity was determined by confirmatory factor analysis (CFA). Measurements of content validity and reading level of the Arabic SDS were included. The Arabic SDS was evaluated in a sample of 164 family caregivers in Jordan by Dalky Heyam (Dalky, 2012).

Stigma reduction interventions—Strategies to reduce stigma can be implemented at different levels: the intrapersonal, interpersonal, organizational/institutional, community, and governmental/structural (Heijnders, Van Der Meij, 2006; McLeroy et al., 1988; Richard et al., 1996). Appendix A includes brief descriptions of these strategies and examples of effective interventions after implementing these strategies. In June 2012, we conducted a search using the PubMed database for stigma-related studies conducted in the Middle East region. We initially identified 2,534 peer reviewed papers using the keywords 'stigma' and 'mental illness'; when the filter 'interventions' was added, the number of citations reduced to 335. When filtered by manuscripts restricted to mental health in English, 154 manuscripts remained. Of these, only six were conducted in the Middle East (Table 1). Five of these studies estimated stigma of mental illness among participants in the Middle East, and one study implemented an intervention designed to decrease stigma among participants.

Studies that estimated stigma of mental illness in the Middle East—In the United Arab Emirates, Eapen and Ghubash (2004) studied factors that influenced parents to seek help for mental health problems in children. They interviewed parents of children with mental health problems (N = 325 parents). Parents reported reluctance to acknowledge that a member of their family had a mental illness. Only 38% of those surveyed indicated that they would seek help from mental health specialists in the event of psychiatric problems developing in a family member, including their children. Stigma attached to using mental health services and skepticism about the usefulness of mental health services were factors that hindered them from seeking help for their children (Eapen & Ghubash, 2004).

A study in Egypt reported that psychiatric disorders are particularly stigmatized and often met with social rejection (Coker, 2005). Stigma led to social disapproval, devaluation of families with mentally ill individuals, and diminished marital prospects. Stigma also increased the social distance between the individuals with mental illness and other individuals; social distance was associated with statements to the effect that a person was 'mad' or 'crazy', harmful to others, or had impaired reasoning. Respondents believed that individuals should be blamed or considered to be responsible for their illness. The cure for such illnesses was placed in the social, not in the personal or biological realm. Lower social distance (i.e., less stigma) was associated with citing 'personal failure,' or social factors as a cause, suggesting social support as a primary treatment, and expressing a moral or religious imperative to help the person. The study also reported that stigmatizing attitudes are greater toward disorders such as alcohol abuse, which is socially unacceptable in the Middle East, but lower for others, like depression, possession, and psychosis. The study reported that

85.5% of the sample (N=208) would not accept a psychotic person as a schoolteacher, and 56.6% would not accept him/her as a family member (Coker, 2005). It was reported that there are no significant gender differences in stigmatization (Al-Krenawi et al., 2000; Baasher et al., 1983; Bassiouni & Al-Issa, 1966; Younis, 1978).

In Saudi Arabia, Shahrour and Rehmani measured the stigmatizing attitudes of the staff of King Abdulaziz Hospital toward patients with mental illness. Hospital staff had high scores (6.8/9) for caring attitude for patients with psychiatric illness. They had medium scores for fear (4/9), avoidance (4.8/9), and dangerousness (4.3/9). They had low scores (3.1/9) for angry feelings toward these patients. Discriminatory behavior was found to result from feeling that these patients are dangerous, not because they were thought to be responsible for their illness (Shahrour & Rehmani, 2009)

In Oman, Al-Adawi and colleagues examined whether social factors influence a person's attitude toward people with mental illness (PWMI); they compared attitudes of medical students, relatives of patients, and members of the community toward PWMI (Al-Adawi et al., 2002). Medical students and members of the community thought PWMI tend to have 'peculiar' and 'stereotypical' appearances, and the majority preferred that facilities for psychiatric care be located away from the community. This study suggested that neither socio-demographic factors nor previous exposure to PWMI was related to attitudes toward PWMI. Although the attitudes of Omanis toward PWMI appear to fluctuate in complex ways, traditional beliefs about mental illness have yet to be altered by exposure to a biomedical model of mental illness. This study largely suggests that the extent of stigma varies according to the cultural and sociological backgrounds of each society (Al-Adawi et al., 2002).

Struch and colleagues (2008) interviewed patients undergoing outpatient psychiatric treatment in Israel. They reported that more than half of service users expected people to refuse to have a person with a mental disorder as a co-worker or neighbor, or to engage in other types of social contact. A substantial proportion acknowledged that they feared or had experienced rejection. A third of respondents reported they feared or had received inappropriate treatment from their physicians. Most respondents preferred to maintain a social distance from persons with mental illness. The experience of stigma and rejection was not confined to those who had been hospitalized. Simply receiving mental health care sufficed to elicit stigma, or the service users themselves felt stigmatized. Consumers of mental health services use a variety of coping mechanisms, like education, withdrawal, and secrecy to help reduce stigma (Struch et al., 2008).

Interventions to Reduce Stigma of Mental Illness in the Middle East—To our knowledge the only evidence-based stigma reduction program undertaken in the Middle East region was implemented in Turkey (Altindag et al., 2006). The educational stigma reduction intervention targeted undergraduate medical students. This intervention included a two-hour lecture about the causes of schizophrenia, screening of a film that depicts an individual with schizophrenia, and contact with a person with schizophrenia. Increased knowledge was associated with lower social distance scores between the undergraduate students and individuals with schizophrenia; favorable attitudinal changes were observed in terms of

‘beliefs about the etiology of schizophrenia, social distance to people with schizophrenia, and care and management of people with schizophrenia.’ Changes in attitudes tended to decrease at the one-month follow up point (Altindag et al., 2006).

Discussion and Recommendations—Although some have suggested that mental illness does not elicit as much stigma in the Arab world as in other societies (Dols, 1992; Fabrega, 1991), recent reports suggest that stigma toward people with mental illness does exist to a substantial extent in the Middle East. This societal stigma influences their treatment. Some mentally ill patients can ‘somatize’ their psychological symptoms and usually go to non-psychiatric health care providers before they reach the psychiatric clinics or hospitals (Okasha & Karam, 1998). Goldberg and Huxley (1992) reported that almost two-thirds of patients with psychiatric symptoms first sought a general practitioner and only about half were diagnosed with a psychiatric disorder. This route coincides with a growing move elsewhere in the world to use the ‘medical model’ for psychiatric illnesses and to seek evidence for biological bases for mental illness to lessen stigma. Other persons with mental illnesses attempt to avoid stigmatization by seeking traditional or faith healers (Okasha & Karam, 1998). For example, in the United Arab Emirates, approximately half (44.8%) of patients suffering from psychiatric disorders sought non-professional care before attending specialized services (Salem et al., 2009). This pattern of health seeking behavior may be influenced by cultural beliefs regarding the role that demonic possession, sorcery, and the evil eye play in provoking symptoms of mental illness. Motivated by these beliefs, many seek help initially from traditional healers. In most Middle Eastern countries, there is no interaction between medical professionals and traditional healers (Okasha et al., 2012).

Routes to stigma reduction have been investigated extensively in western countries, and several solutions have been developed and tested (see Appendix). Before they can be recommended in Middle Eastern countries, however, it is important to consider cultural differences between countries in this region and western countries. It is also important to note that Middle Eastern countries also differ from each other in several socio-cultural dimensions, so uniform solutions may not succeed. On the other hand, the majority of individuals in this region belong to the Muslim faith, so consideration of the relevant religious teachings is important. Though it makes no specific statements about the treatment of mental illnesses, the Q’uran states, ‘There is no blame on the blind, nor is there blame on the lame, nor is there blame on the sick’ (Al-Fath 48:17). This humane attitude is contradicted by some scholars, who suggest that Islam views mental illness as a condition that results from an unbalanced lifestyle (diet, sleeping pattern, spiritual activities and remembrance of god) (Rahman, 1998). According to other scholars, traditional Middle Eastern culture is not accepting of mental illness; moreover the traditionally strong family relationships in the Middle East and Arab culture mean that admission of a family member to a psychiatric hospital produces a stigmatizing label not only for the patient but for all members of his or her family (Okasha et al., 2012).

Keeping these concerns in mind, we propose four sets of interventions that could reduce the stigma related to mental illness. Appropriate metrics to investigate the impact of each intervention are also needed.

- i. Educate families to support their affected members in overcoming shame and seeking treatment. The majority of Egyptian respondents in one survey believed that social support would be the most effective treatment for the disorders mentioned in the vignettes (Coker, 2005). Social support was seen not only as the responsibility of the family, but also of friends, neighbors, and the entire community in this survey. Social support can be achieved by building qualified teams in psychiatric hospitals who can begin to educate families as soon as a family members admitted to the hospital. Following discharge of the patient from the inpatient unit, the teams should engage in outreach.
- ii. Engage traditional healers. Traditional (faith) healers are often the first line of intervention for mental health symptoms, yet there is little interaction between medical professionals and traditional healers (Okasha et al., 2012). Cooperation between psychiatrists and faith (religious) healers can be effective in reducing the stigma by enabling healers to encourage patients to seek help from mental health specialists. On the other hand, there is likely to be concern among psychiatrists about erroneous beliefs held by traditional healers that could reinforce stigma.
- iii. Engage religious leaders. Religious leaders could be engaged by marshaling religious teachings that admonish individuals from discriminating against mentally ill persons. If religious leaders in the community 'adopt' particular patients, they can use their leadership to reduce the social distance between the community and the mentally ill patients. Furthermore, the leaders could also direct individuals with mental health problems to seek treatment from mental health facilities.
- iv. Educate young persons. Education, particularly for young people, will help to increase awareness about the nature of mental illnesses. We also recommend that the curricula in high schools, medical, nursing, and ancillary mental health training facilities should address the issue of stigma related to the mental illness. Some studies have indicated that even mental health professionals do not differ statistically from members of communities in their stigmatizing attitudes toward mental illness (Nordt et al., 2006). Thus, exposing mental health professionals before they start their professional careers could equip them better to deal with this phenomenon.

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References

1. Ablon J. The Nature of Stigma and Medical Conditions. *Epilepsy and Behavior*. 2002; 3(6 Suppl.2): 2–9. [PubMed: 12609300]
2. Al-Adawi S, Dorvlo AS, Al-Ismaily SS, Al-Ghafry DA, Al-Noobi BZ, Al-Salmi A, Burke DT, Shah MK, Ghassany H, Chand SP. Perception of and attitude towards mental illness in Oman. *Int J Soc Psychiatry*. 48(4):305–317. [PubMed: 12553410]
3. Al-Krenawi A, Graham JR, Kandah J. Gendered utilization differences of mental health services in Jordan. *Community Ment Health J*. 2000; 36(5):501–511. [PubMed: 10994683]

4. Alexander LA, Link BG. The impact of contact on stigmatizing attitudes towards people with mental illness. *Journal of Mental Health*. 2003; 12:271–289.
5. Altindag A, Yanik M, Ucok A, Alptekin K, Ozkan M. Effects of an antistigma program on medical students' attitudes towards people with schizophrenia. *Psychiatry Clin Neurosci*. 2006; 60(3):283–288.10.1111/j.1440-1819.2006.01503.x [PubMed: 16732743]
6. Angermeyer MC, Matschinger H. The effect of personal experience with mental illness on the attitude toward individuals suffering from mental disorders. *Social Psychiatry and Psychiatric Epidemiology*. 1996; 31(6):321–326. [PubMed: 8952371]
7. Baasher T, Elhakim AS, el Fawal K, Giel R, Harding TW, Wankiiri VB. On vagrancy and psychosis. *Community Ment Health J*. 1983; 19(1):27–41. [PubMed: 6571483]
8. Bassiouni W, Al-Issa I. Psychiatry in Iraq. *British Journal of Psychiatry*. 1966; 112:827–832. [PubMed: 5966556]
9. Benbow C, Tamiru T. The experience of self-care groups with people affected by leprosy: ALERT, Ethiopia. *Leprosy Review*. 2001; 72:311–312. [PubMed: 11715277]
10. Brohan E, Slade M, Clement S, Thornicroft G. Experiences of mental illness stigma, prejudice and discrimination: a review of measures. *BMC Health Serv Res*. 2010; 10:80.10.1186/1472-6963-10-80 [PubMed: 20338040]
11. Brown L, MacIntyre K, Trujillo L. Interventions to reduce HIV/AIDS stigma: What have we learned? *AIDS Education and Prevention*. 2003; 15:9–69.
12. Busza JR. Promoting the positive: Responses to stigma and discrimination in Southeast Asia. *AIDS Care*. 2001 Aug; 13(4):441–56. 2001. [PubMed: 11454265]
13. Byrne P. Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment* (2000). 2000; 6:65–72.10.1192/apt.6.1.65
14. Campbell, J.; Schraiber, R. *The well-being project: Mental health clients speak for themselves*. Sacramento, CA: 1989.
15. Coker EM. Selfhood and social distance: toward a cultural understanding of psychiatric stigma in Egypt. *Soc Sci Med*. 2005; 61(5):920–930.10.1016/j.socscimed.2005.01.009 [PubMed: 15955396]
16. Corrigan PW. The impact of stigma on severe mental illness. *Cognitive and Behavioral Practice*. 1998; 5(2):201–222.
17. Corrigan PW, Edwards AB, Green A, Diwan SL, Penn DL. Prejudice, social distance, and familiarity with mental illness. *Schizophr Bull*. 2001; 27(2):219–225. [PubMed: 11354589]
18. Corrigan, Patrick W.; Calabrese, Joseph D. Strategies for Assessing and Diminishing Self-Stigma. In: Corrigan, P., editor. *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*. Washington, DC: American Psychological Association; 2004. p. 239-256.
19. Corrigan PW, Matthews AK. Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health*. 2003; 12(3):235–248. 2003.
20. Corrigan PW, Miller FE. Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*. 2004; 13(6):537–548.
21. Corrigan PW, Penn DL. Lessons from social psychology on discrediting psychiatric stigma. *Am Psychol*. 1999; 54(9):765–776. [PubMed: 10510666]
22. Corrigan PW, River LP, Lundin RK, Wasowski KU, Champion J, Mathisen J, Goldstein H, Bergman M, Gagnon C, Kubiak MA. Stigmatizing attributions about mental illness. *Journal of Community Psychology*. 2000; 28(1):91–102.
23. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. *World Psychiatry*. 2002 Feb; 1(1):16–20. 2002. [PubMed: 16946807]
24. Cumming, E.; Cumming, J. *Closed Ranks: An Experiment in Mental Health*. Harvard University Press; Cambridge: 1957.
25. Dalky HF. Arabic translation and cultural adaptation of the stigma-devaluation scale in Jordan. *J Ment Health*. 2012; 21(1):72–82.10.3109/09638237.2011.629238 [PubMed: 22257132]
26. Demissie M, Getahun H, Lindtjörn B. Community tuberculosis care through “TB clubs” in rural North Ethiopia. *Soc Sci Med*. 2003 May; 56(10):2009–18. 2003. [PubMed: 12697193]
27. Dols, MW. *Majnuun: the madman in medieval Islamic society*. Oxford: Clarendon Press; 1992.

28. Dovidio JF, Gaertner SL. Affirmative Action, Unintentional Racial Biases, and Intergroup Relations. *Journal of Social Issues*. 1996; 52(4):51–75. [PubMed: 15156861]
29. Eapen V, Ghubash R. Help-seeking for mental health problems of children: preferences and attitudes in the United Arab Emirates. *Psychol Rep*. 2004; 94(2):663–667. [PubMed: 15154199]
30. Esters IG, Cooker PG, Ittenbach RF. Effects of a unit of instruction in mental health on rural adolescents' conceptions of mental illness and attitudes about seeking help. *Adolescence*. 1998 Summer;33(130):469–76. 1998. [PubMed: 9706332]
31. Fabrega H Jr. Psychiatric stigma in non-Western societies. *Compr Psychiatry*. 1991 Nov-Dec;32(6): 534–51. 1991. [PubMed: 1778081]
32. Gewirtz A, Gossart-Walker S. Home-based treatment for children and families affected by HIV and AIDS. Dealing with stigma, secrecy, disclosure, and loss. *Child Adolesc Psychiatr Clin N Am*. 2000 Apr; 9(2):313–30. 2000. [PubMed: 10768069]
33. Goffman, E. *Stigma: Notes in the management of spoiled identity*. New Jersey: Prentice-Hall; 1963.
34. Goldberg D. A bio-social model for common mental disorders. *Acta Psychiatr Scand Suppl*. 1994; 385:66–70. 1994. [PubMed: 7740974]
35. Gordon H, Murad I. Psychiatry and the Palestinian population. *Isr J Psychiatry Relat Sci*. 2005; 42(2):73–80. 2005. [PubMed: 16342602]
36. Graf J, Lauber C, Nordt C, Ruesch P, Meyer PC, Rossler W. Perceived stigmatization of mentally ill people and its consequences for the quality of life in a Swiss population. *Journal of Nervous and Mental Disease*. 2004; 192(8):542–547.10.1097/01.nmd.0000135493.71192.3a [PubMed: 15387156]
37. Gray A. Stigma in psychiatry. *J R Soc Med February*. 2002; 95(2):72–76.
38. Hall PL, Tarrier N. The cognitive-behavioural treatment of low self-esteem in psychotic patients: a pilot study. *Behav Res Ther*. 2003 Mar; 41(3):317–32. 2003. [PubMed: 12600402]
39. Harrow M, Jobe TH. Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: a 15-year multifollow-up study. *J Nerv Ment Dis*. 2007 May; 195(5): 406–14. 2007. [PubMed: 17502806]
40. Heijnders M, Van Der Meij S. The fight against stigma: an overview of stigma-reduction strategies and interventions. *Psychol Health Med*. 2006; 11(3):353–363.10.1080/13548500600595327 [PubMed: 17130071]
41. Hinshaw SP, Cicchetti D. Stigma and mental disorder: conceptions of illness, public attitudes, personal disclosure, and social policy. *Dev Psychopathol*. 2000; 12(4):555–598. [PubMed: 11202034]
42. Holmes EP, River LP. Individual strategies for coping with the stigma of severe mental illness. *Cognitive and Behavioral Practice*. 1998; 5(2):231–239.
43. Hyler SE, Gabbard GO, Schneider I. Homicidal maniacs and narcissistic parasites: stigmatization of mentally ill persons in the movies. *Hosp Community Psychiatry*. 1991; 42(10):1044–1048. [PubMed: 1959896]
44. Kessler RC, Berglund PA, Bruce ML, Koch R, Laska EM, Leaf PJ, et al. The prevalence and correlates of untreated serious mental illness. *Health Services Research*. 2001; 36:987–1007. [PubMed: 11775672]
45. Link B. Mental patient status, work, and income: An examination of the effects of a psychiatric label. *American Sociological Review*. 1982 Apr; 47(2):202–15. 1982. [PubMed: 7091929]
46. Link B. Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*. 1987; 52(1):96–112.
47. Link BG, Struening EL, Neese-Todd S, Asmussen S, Phelan JC. Stigma as a barrier to recovery: The consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatr Serv*. 2001; 52(12):1621–1626. [PubMed: 11726753]
48. Lyon ME, Woodward K. Nonstigmatizing ways to engage HIV-positive African-American teens in mental health and support services: A commentary. *Journal of the National Medical Association*. 2003 Mar; 95(3):196–200. 2003. [PubMed: 12749679]
49. McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Educ Q*. 1988; 15(4):351–377. [PubMed: 3068205]

50. Mehta SI, Farina A. Associative stigma: Perceptions of the difficulties of college-aged children of stigmatized fathers. *Journal of Social and Clinical Psychology*. 1988; 7:192–202. Special Section: Attributions. 10.1521/jscp.1988.7.2-3.192
51. Meise U, Sulzenbacher H, Kemmler G, Schmid R, Rössler W, Gunther V. “... Not dangerous, but nevertheless frightening”: a program against stigmatization of schizophrenia in schools. *Psychiatr Prax*. 2000 Oct; 27(7):340–6. 2000. [PubMed: 11103395]
52. Mohit A. Mental health and psychiatry in the Middle East: historical development. *East Mediterr Health J*. 2001; 7(3):336–347. [PubMed: 12690751]
53. Muyinda H, Seeley J, Pickering H, Barton T. Social aspects of AIDS-related stigma in rural Uganda. *Health Place*. 1997 Sep; 3(3):143–7. 1997. [PubMed: 10670965]
54. Narrow WE, Regier DA, Norquist G, Rae DS, Kennedy C, Arons B. Mental health service use by Americans with severe mental illnesses. *Social Psychiatry & Psychiatric Epidemiology*. 2000 Apr; 35(4):147–55. 2000. [PubMed: 10868079]
55. Nordt C, Rössler W, Lauber C. Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophr Bull*. 2006; 32(4):709–714. 10.1093/schbul/sbj065 [PubMed: 16510695]
56. Nyblade, L.; Pande, R.; Mathur, S.; MacQuarrie, K.; Kidd, R., et al. Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia. International Center for Research on Women; Washington, DC, USA: 2003. p. 53
57. Okasha A. Mental health in Egypt. *Isr J Psychiatry Relat Sci*. 2005; 42(2):116–25. 2005. [PubMed: 16342608]
58. Okasha A, Karam E. Mental health services and research in the Arab world. *Acta Psychiatr Scand*. 1998; 98(5):406–413. [PubMed: 9845180]
59. Okasha A, Karam E, Okasha T. Mental health services in the Arab world. *World Psychiatry*. 2012; 11(1):52–54. [PubMed: 22295010]
60. Osgood, CE.; Suci, GJ.; Tannenbaum, PH. The measurement of meaning. Urbana: University of Illinois Press; 1957.
61. Pandya A. NAMI in our own voice and NAMI smarts for advocacy: self-narrative as advocacy tool. *Journal of Psychiatric Practice*. 2012 Nov; 18(6):448–50. 10.1097/01.pra.0000422744.79871.1a [PubMed: 23160251]
62. Piner KE, Kahle LR. Adapting to the stigmatizing label of mental illness: foregone but not forgotten. *Journal of Personality and Social Psychology*. 1984; 47(4):805–811. [PubMed: 6512683]
63. Pinfold V, Toulmin H, Thornicroft G, Huxley P, Farmer P, Graham T. Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry*. 2003 Apr; 182:342–6. 2003. [PubMed: 12668411]
64. Pridmore S, Pasha MI. Psychiatry and Islam. *Australas Psychiatry*. 2004 Dec; 12(4):380–5. 2004. [PubMed: 15715812]
65. Prior S. Overcoming stigma: how young people position themselves as counseling service users. *Sociology of Health and Illness*. 2012 Jun; 34(5):697–713. 2012. Epub 2011 Oct 25. 10.1111/j.1467-9566.201101430.x [PubMed: 22026466]
66. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*. 1993; 50(2):85–94. [PubMed: 8427558]
67. Richard L, Potvin L, Kishchuk N, Prlic H, Green LW. Assessment of the integration of the ecological approach in health promotion programs. *American Journal of Health Promotion*. 1996; 10(4):318–328. [PubMed: 10159711]
68. Rothbart M, John OP. Social categorization and behavioral episodes: a cognitive analysis of the effects of intergroup contact. *Journal of Social Issues*. 1985; 41(3):81–104.
69. Ritsher JB, Otilingam PG, Grajales M. Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry Research*. 2003; 121(1):31–49. [PubMed: 14572622]
70. Rusch N, Angermeyer MC, Corrigan PW. Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*. 2005; 20:529–539. [PubMed: 16171984]

71. Salem MO, Saleh B, Yousef S, Sabri S. Help-seeking behaviour of patients attending the psychiatric service in a sample of United Arab Emirates population. *International Journal of Social Psychiatry*. 2009; 55(2):141–8. [PubMed: 19240203]
72. Shahrour TM, Rehmani RS. Testing psychiatric stigma in a general hospital in Saudi Arabia. *Saudi Medical Journal*. 2009 Oct; 30(10):1336–9. 2009. [PubMed: 19838444]
73. Smith M. Stigma. *Advances in Psychiatric Treatment*. 2002; 8:317–323. 2002.
74. Socall DW, Holtgraves T. Attitudes toward the mentally ill: The effects of label and beliefs. *Sociol Q*. 1992; 33(3):435–445.
75. Sonn T. Health and Medicine in the Islamic Tradition: Fazlur-Rahman's view. *Journal of the Islamic Medical Association of North America*. 1996; 28(4):5915/28-4-8094
76. Struch N, Levav I, Shereshevsky Y, Baidani-Auerbach A, Lachman M, Daniel N, Zehavi T. Stigma experienced by persons under psychiatric care. *Isr J Psychiatry Relat Sci*. 2008; 45(3):210–218. [PubMed: 19398825]
77. Struening EL, Cohen J. Factorial invariance and other psychometric characteristics of five opinions about mental illness factors. *Educational and Psychological Measurement*. 1963; 23(2):289–298.
78. Stuart H, Milev R, Koller M. The Inventory of Stigmatizing Experiences: its development and reliability. *World Psychiatry*. 2005; 4:33–37. [PubMed: 16633500]
79. Tanaka G, Ogawa T, Inadomi H, Kikuchi Y, Ohta Y. Effects of an educational program on public attitudes towards mental illness. *Psychiatry and Clinical Neurosciences*. 2003 Dec; 57(6):595–602. 2003. [PubMed: 14629708]
80. Tringo JL. The hierarchy of preference toward disability groups. *Journal of Special Education*. 1970; 4(3):295–306. 1970. 10.1177/002246697000400306
81. Wahl, O. Media madness: Public images of mental illness. New Brunswick, NJ: Rutgers University Press; 1995.
82. Weiner B, Perry RP, Magnusson J. An attributional analysis of reactions to stigmas. *J Pers Soc Psychol*. 1988; 55(5):738–748. [PubMed: 2974883]
83. Younis YO. Attitudes of Sudanese urban and rural population to mental illness. *J Trop Med Hyg*. 1978; 81(12):248–251. [PubMed: 748570]

Table 1

Studies of psychiatric stigma in the Middle East

Study/country	Design	Target population	Intervention/Strategy	Outcomes/Results
Eapen V, Ghubash R, 2004 (United Arab Emirates)	Community-based study	Parents of children having mental health problems (N=325)	Survey using a semi-structured interview schedule	Only 38% indicated they would seek help from mental health specialists if a psychiatric problem developed in a family member. Reasons: reluctance to acknowledge that a family member has a mental illness, stigma attached to mental health services, and skepticism about usefulness of mental health services.
Coker, 2005 (Egypt)	A vignette method was used to elicit judgments of social distance and responses to stories depicting psychosis, depression, alcohol abuse and a 'possession state'	Community dwellers from different work settings (N=208)	Trained researchers interviewed the public using eight clinical vignettes to assess beliefs and attitudes about mental illness and treatment	Participants reported that behavioral disorders are particularly stigmatized and often met with social rejection. They also think that individual blame is diffused as responsibility for the illness and its cure is placed in the social, not personal (biological) realm.
Shahrour, Rehmani, 2009 (Saudi Arabia)	Measuring the stigma of psychiatric illnesses.	Hospital staff of King Abdulaziz Hospital (Jeddah, Saudi Arabia) (N=860)	A cross-sectional study through internal mail was carried out on all the hospital staff.	Hospital staff had high scores (6.8/9) for caring attitudes for patients with psychiatric illness. They had medium scores for fear (4/9), avoidance (4.8/9), and dangerousness (4.3/9). They had low scores (3.1/9) for anger feelings toward these patients.
Al-Adawi, Dorvlo, Al-Ismaily, Al-Ghafry, Al-Noobi, Al-Salmi, Burke, Shah, Ghassany, Chand, 2002 (Oman)	Examine if social factors exert an influence on a person's attitude toward people with mental illness (PWMI)	Medical students, relatives of patients, and community members. (N=468)	Measuring and comparing attitudes of medical students, relatives of patients, and general public toward (PWMI) through a questionnaire	Medical students and non-medical persons thought that PWMI tend to have peculiar and stereotypical appearances and the majority preferred that facilities for psychiatric care should be located away from the community. Although relatives of PWMI were concerned about the welfare of mental patients, their responses varied and were often contingent upon their expectations.
Struch N, Lachman M, 2008 (Israel)	Addressing the existence and effects of stigma	Adults undergoing outpatient psychiatric treatment. (N=167)	Interviews with patients	Over half of services users expect people to refuse to have a person with a mental disorder as a co-worker or neighbor, or to engage in social contact. A sizeable group acknowledged that they feared or had experienced rejection. A third of respondents reported they had inappropriate treatment by their doctor.
Altindag, Yanik, Uçok, Alptekin&Ozcan, 2006 (Turkey)	Pre- and post-test with control group, quasi-experimental design (1-month follow up)	Undergraduate college students (N=60)	1-day pilot program: Education: 2-hr lecture; causes of stigma associated with schizophrenia, common myths about schizophrenia, relationship	Post-intervention: participants had more knowledge about causes of schizophrenia and had lower social distance score. Post-intervention:

Study/country	Design	Target population	Intervention/Strategy	Outcomes/Results
			and violence. Direct contact with a person with schizophrenia, indirect contact (watching a film 'A Beautiful Mind')	participants had higher scores of social distance

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