A Literature Review of Healthcare Professionals' Attitudes towards Patients with Mental Illness

Waleed Alshahrani[1,2*]

[1]School of Health Sciences, Kent State University, USA

[2]College of Applied Medical Sciences, Taif University, Saudi Arabia

*Corresponding author: Waleed Alshahrani, School of Health Sciences, Kent State University, USA, Tel: 0012345257370; E-mail: walshahr@kent.edu

Citation: Alshahrani W (2018) A Literature Review of Healthcare Professionals' Attitudes towards Patients with Mental Illness. J Med Res Health Educ. Vol. 2 No. 1: 5.

Abstract

Background: The purpose of this review of literature is to examine the problem of stigma and discrimination in the provision of mental health care. The author will review the literature available from research and assessments in relation to this topic as well as the problems faced in research and proposed solutions to this phenomenon. Topics requiring further research into bettering the situation of both the patient and the health care service provider will be highlighted.

Objective: To inventory and organize the peer-reviewed literature related to attitudes of health professionals towards the mentally ill and to identify shifts in research focus from risk evaluation to intervention and reduction. To consider research directions with clear applications for improved care and care outcomes.

Methods: A comprehensive review of the peer-reviewed literature was conducted to retrieve empirical studies that addressed attitudes of health professionals towards the mentally ill. A matrix was created to determine the capacity, quality, and characteristics of 47 research studies conducted between 1996 and 2014, all pertaining to attitudes of health professionals towards patients with mental illness.

Results: A synthesis of these empirical studies revealed an emerging literature related to attitudes of healthcare professionals towards the mentally ill and the consequences of limited information focusing on patients' perspectives.

Conclusions: Amid growing trends in numerous countries of healthcare professionals' negative attitudes towards the mentally ill, the need for further research is clear. Researchers must fill gaps in literature concerning appropriate strategies and techniques to minimize negative attitudes among healthcare providers.

Introduction

In professional clinics, hospitals, and other workplace settings, negative attitudes can affect physicians and other healthcare professionals in terms of patients' treatment [1,2]. According to Corrigan et al. and Wahl negative attitudes are suppressed by the majority of primary care physicians. In addition, even productive physicians harboring minor negative attitudes can be involved in such unwanted behavior as discrimination [1,2]. Attitudes and beliefs about mental illness are shaped by an individual's knowledge of mental illness; in turn, these attitudes and beliefs shape one's understanding and communication with persons living with mental illness. Apart from self-examination, health providers are as susceptible as any member of a culture to the cultural stereotypes operant in context [1,2]. In contrast, attitudes and beliefs, which reflect positively on mental illness, may result in supportive behaviors (example, willingness to communicate with a person with mental illness or to recruit a person who is diagnosed with mental illness). When, however, attitudes and beliefs are negatively informed, then the results may be exclusion from daily activities, avoidance and, in worst cases, discrimination [3].

Regardless of the caliber of any prescribed regimen for people with a mental disorder, the success of treatment could still be adversely affected by such factors as stigma attached to particular diagnosed illness, negative beliefs and expectations about treatment, and the healthcare providers' attitudes. These independent but concurrent factors critically complicate treatment inasmuch as professional bias can add to the magnitude of the stigma a patient may encounter [4]. The effects cannot be ignored in the assessment of mental healthcare provision, both the quantity and quality of care. Tehrani et al. found that the biggest factor that has influenced the decision to abstain from contacting mental health

specialists is dissatisfaction. They also found that dropout rates are higher for people who believe psychiatric treatment is ineffective and those embarrassed to be seen by mental health professionals.

Stigma does not exist as a single domain, but in a professional healthcare setting, one needs to be particularly conscious of internalized stigma he or she might perpetuate because of the high stakes in place [5]. Studies should be undertaken to determine the effectiveness of mental health interventions in environments polluted by negative attitudes between the medical personal and the patients. Studies should consider the opinions of patients regarding the outcomes of their treatments before commencing with those treatments [5]. There is disturbing consensus among most patients and indeed, larger society, who believe that most psychiatric regimens are debilitative, sedative and inefficient to the point of provoking more harm than good [6].

Stigma is a product of the attitudes of members of the society toward a group of persons that are classifiable by some common characteristic that the society denigrates [7,8]. Stigma upsets a person's self-esteem, escalates dysfunction, and poses problems to patients with respect to such basic needs as housing and employment. If one views recovery as a process, stigma may rightly be viewed as a socially induced obstacle to this recovery process [7,8].

Methods

Review of the literature

A comprehensive review of the literature was conducted by using library databases to retrieve empirical articles that addressed attitudes of health professionals towards the mentally ill. Select literature was used in compiling this review from articles in relevant journals including but not limited to the British Journal of Psychiatry, International Journal of Social Psychiatry, Epidemiologiae Psichiatria Sociale, Journal of Ethics in Mental Health and Neuropsychiatric Disease and Treatment journal. Years included in the review were varied in order to accommodate classical works and important works cited in other recent literature. Most studies however were post-1996 up to 2014. Databases searched included the National Center for Biotechnology Information database, PubMed database and the Research Gate database. Search terms included 'stigma', 'discrimination', attitudes', 'schizophrenia', 'mental illness' and 'psychiatrist'.

Inclusion criteria allowed materials written in the English-language, committee papers, empirical research reports, research published in peer-reviewed journals, and professional commentaries. Research reports from educational, government, reputable research institutions, and not-for-profit agencies were also included. Exclusion criteria disallowed fictional works, dissertations, theses, and any study that did not address attitudes of health professionals towards the mentally ill. Materials from non-scientific web pages were also excluded (e.g., Social networking sites, Wikipedia, research blogs, web sites in any language other than English and

personal web pages). Although the search retrieved early studies from the 1990s, potentially useful for their historical perspective about attitudes towards the mentally ill, the author purposively targeted studies published in the subsequent three decades from 1990 to 2014. In acknowledgement of the rapid growth of medical education as well as the growing and widespread recognition of this behavioral risk topic, the author chose to omit literature published before 1990.

The author concentrated on this latest time period because these studies provide significant snapshots of attitudes toward mentally ill across several countries. Also of interest were studies with in-depth focus, such as, studies connecting attitudes to a specific behavior, differentiating between attitudes relative to experienced stigma, or tracking attitudes toward mental illness at the state level.

Data extraction and analysis

This literature review was written in accordance with the Matrix Method established by Garrard. Every publication was extracted for sample locale and sample characteristics. Types of healthcare professionals and stigmatizations, healthcare professionals' attitudes towards mentally ill, attitudes of patients in use of mental health services, major determinants to negative attitudes, and discussion were also categorically abstracted from the literature. The matrix was created to define the amount, value, quality, and features of research studies pertaining to these topics.

Findings

Articles included in the literature review

A total of 47 articles from seven countries met study inclusion criteria and were included in the matrix. Ten empirical research studies utilized samples that included mental health professionals' attitudes, and six of these studies focused on psychiatrists' attitudes [9-14]. Eight studies involved stigmatizing attitudes towards people with mental disorders [12,13,15-20], whereas four studies investigated discrimination in health care against people with mental illness [21-24]. As to the samples employed, there are studies whose samples depict general public attitudes [10-12,25], as well as medical students' attitudes [15], Strategies to reduce stigma were highlighted by Rüsch et al.

Types of healthcare professionals and stigmatizations

This matrix documented the types of healthcare professionals and stigmatizations in the current literature. A total of twelve articles dealt with different types of healthcare professionals and stigmatizations as major determinants of their negative attitudes behavior towards mentally ill [9-20,26], and five of these studies considered types of healthcare professionals and stigmatizations as an experimental measure [15,16,19,20,26]. **Table 1** provides more

details about the healthcare professionals and stigmas included in this review article.

Table 1 Types of healthcare professionals and stigmatizations in the reviewed articles. Total articles that discuss attitudes of health professionals towards the mentally ill in this review were 47.

Types of participants and healthcare professionals	Type of stigmatizations	Attitudes	Number of reviewed articles
Mental Health Professionals	Stereotypes due to long-term outcomes	Mostly Negative	4 (16%)
Registered or Assistant Nurses	Perceived mental health patients as being more dangerous and unpredictable	Mostly Negative	4 (16%)
Psychiatrists	Most reported, discomfort about long-term outcomes and prognosis specially with those who have had a prior history of alcohol dependence and admitted to a psychiatric ward for schizophrenia	Mostly Negative	7 (28%)
Clinical Psychologists and Psychologists	Discomfort even professionals experience with a psychiatric diagnosis such as schizophrenia	Mostly Negative	3 (12%)
General Public	Avoidance and characterized mentally ill as unpredictable	Mostly Negative	6 (24%)
Students	Social distance	Mostly positive	2 (8%)
Mental Health Hospital Employees	Between 60% and 80% of all employees agreed that unusual behavior and peculiar ideas are always present; insults and obscene language are invariably found in all mental patients	Mostly Negative	1 (4%)
Patients with Mental Illness	None	Mostly uncomfortable	5 (20%)
General Practitioners	Helpfulness yet discomfort working with patients with mental disorders	Mostly positive	2 (8%)
Other health care professionals	Felt fear to have contact with patients with mental illness or treat	Mostly Negative	4 (16%)
Literature Review Research	Most reviews indicated that psychiatrists, in trying to offer and provide assistance to people with mental illnesses, are not necessarily straightforward	Mostly Negative	5 (20%)

Attitudes of healthcare professionals towards patients with mental illness

Several studies, of the 41 reviewed, cited the differing attitudes of healthcare professionals (psychiatrists, psychologists, nurses, and students as well as others) towards their patients [9-11,13,14,27-29]. Psychologists, these studies found, have the most negative attitudes towards mental health patients. This attitude, insofar as it was measured here, is not affected by gender but is affected by age, with younger mental health professionals holding a more negative view than the older, more experienced professionals. However, Thompson-Brenner et al. specifically found that the gender of the clinician could, in fact, be relevant in that males showed more negativity than females.

In review articles presented by Antonio et al. and Thompson-Brenner et al. the consensus was that most of healthcare providers consider the patients to be dangerous and unpredictable. Also, they found that 55% of providers reported that patient resistance was the hardest aspect of their job, making it more likely for them to refer a patient. Some even expressed beliefs that the patients are weak and to blame for their affliction. The most negative attitudes are reserved for chronically ill patients with a history of hospital admissions, for example, patients with schizophrenia. Intensely negative attitudes occur more rarely towards

patients with milder symptoms [7]. In contrast, Murray and Steffen found in their study that most psychologists in the UK (91%) oppose the position that schizophrenia is too severe for them to treat. Granted, most community mental health workers reported greater satisfaction with results of their work the more they interacted with recovering patients who were fully functional members of the society [30]. This was a product of increased autonomy in their practice. However, such variations, even contradictions, in the opinions and attitudes of professionals may fuel confusion among the patients [6]. More than 17% of patients experienced prejudice when treated for physical health care problems. More than 38% of the participants felt disrespected by mental health staff [21].

Sadly, the consequences are potentially dire. Several studies conducted by Jones et al. [31]; McCreadie et al. [32]; Phelan et al. [33] and McCreadie [34] found that even though the incidence of physical disease is higher in those with mental illness, it is an established fact that they receive inferior care for afflictions such as diabetes, HIV, obesity and heart disease. This has the potential to be a lethal combination that causes the death of many mental health patients from otherwise manageable conditions.

McKay found that professional journals on mental health permitted the running of advertisement campaigns by

pharmaceutical companies that were littered with connotations of prejudice. He reasoned that the existence of such condoned messages among those who should know better could be a driving force permitting the society at large to cling to their beliefs on mental illness. In essence, the negative portrayal of the mentally ill by healthcare professionals was rubber-stamping the cruel stigma experienced by patients [35].

Loch et al. [36] in a study of Brazilian psychiatrists found that there were three categories grouped by the attitudes they had. The first group was the 'no-stigma' psychiatrist who did not support restrictions on movement and association; they were mostly representative of the older generation of psychiatric experts. This would lend credence to the fact that prolonged contact with patients' yields positive influence on attitudes. The second group was the 'great-stigma' profile. This was representative of 31-40-year-old psychiatrists who were a majority in the study. They also had 5-10 years of experience since graduation. The profile showed very negative attitudes towards the patients, encouraging restriction, and social distance. Also note that they rarely had family members who were mentally ill. The third group was the 'unobtrusive-stigma.' They were younger psychiatrists whose attitudes matched that of the general population and the mental patients, too. They polled the lowest figures for segregation, supported involuntary admission, and also showed the highest levels of prejudice. The study reveals that apart from experience, personal traits like age and social profile affect the attitudes of mental health professionals.

Attitudes of patients in use of mental health services

Earlier studies indicated that mental health professionals hold fewer stigmatizing attitudes than the general population [10,12,22] however, several of the articles reviewed here noted that psychiatrists had more negative stereotypes than the general population [25,27,37]. Other researchers found the failure to distinguish between mental illness and diminished mental capacity has led to branding patients as crazy when they seek treatment [23]. This has caused them to be kept under constant surveillance. Many still complain that the staff is disinterested in them as individuals. The standard treatment on arrival has been limited to sedation in many cases. The rest of the regimen is pharmacological. This has led to a state of neglect of their emotional and social needs [23]. Thornicroft et al. also found that in most cases the diagnosis of mental illness came with a negative prognosis. Most patients were told that they would be ill all their lives. This limits motivation for recovery; indeed, any semblance of functionality might well be ignored. When patients seek treatment for a variety of somatic problems, their mental history predisposes them to others' assumptions that their illness is imagined and not real. In most cases, they are referred to 'specialists' for no good reason.

Several studies conducted by Filipic et al.; Hassan et al. [38]; Schulze et al. found patients with mental illness such as schizophrenia are faced with the stereotype of being violent and dangerous. This labeling has led to their separation from society. Their encounters with medical staff they assume, are more knowledgeable on the disease, have revealed that common stereotypes are upheld. They also found that 37% of general hospital staff was afraid of patients with mental illness such as schizophrenia, and 21% believed them particularly violent and dangerous. They stated that among the nurses in Turkey, there were more negative attitudes than among physicians. They also assessed the prevalence of mental illness among medical staff and the attitudes of medical professionals towards the services being offered in the institutions. They found that 25.8% of the respondents felt that the cases of mental illness were higher among medical staff than the general population. About 6.2% were of the opinion that psychiatrists were more likely to experience mental illnesses. They observed 306 cases of ill medical staff. From these same studies, some investigations show that professionals' health-seeking behavior is more complicated in the case of mental illnesses; medical staff was often not willing to disclose their status as mentally ill patients. The typical reasons were that the disclosure would put their career in jeopardy. Nineteen percent of the staff was not willing to disclose their illness to anyone because of the stigma associated with it [6,20,38,39]. More recent research has also concluded that the stigma faced by the mental patients is well known even to the medical staff accused of propagating most of it. To reinforce this, they carried out as study of 50 respondents sampled from the staff at the hospital. About 60 percent of the respondents answered that they would be embarrassed to notify friends and acquaintances if they were mentally ill? Seventeen of them, 34 percent, said that it was because they feared stigma [8,40-42]. Additionally, conditions in the psychiatric wards were also a factor that contributed to negative attitudes of psychiatric patients [8]. For example, the size of the rooms and the large number of patients present a case where personalization of treatment regimens is almost impossible. The atmosphere in these wards is abhorrent and demoralizing [8]. The majority of patients expected rejection, discrimination and stigmatization by society after their diagnosis [8].

Major determinants of negative attitudes

In a brief summary, according to Chikaodiri [40] and Yadav et al. [43], the determinants of mental health professionals' attitudes towards their patients include deeply rooted cultural beliefs and traditions as well as the amount of exposure to mentally ill patients, any existence of mental illness in their own families and personal traits, including age and level of education.

Discussion

This review of the literature described the status of patients with mental illness research and identified potential research deficiencies regarding healthcare professionals' attitudes while treating the mentally ill. Moreover, this review highlights the small amount of research related to healthcare services on stigma and discrimination against people with schizophrenia. Within this research, efforts are made to define the nature,

direction, severity of predicted and experienced discrimination as stated by individuals with schizophrenia.

As such, the most recent focus in attitudinal research has been on the mentally ill and their treatment satisfaction during the years where they are still considered unpredictable people. While this is clearly a significant field of research, the evolving evidence and varying demographics in the US may direct us towards a new area of study: namely, patients with mental disorders who are adapting to real conditions of disrespect by healthcare providers and periods in treatment careers where skill levels are fading.

Given the increase in numbers of unethical behaviors and the specific practice of them by healthcare providers from psychiatrists, psychologists and nurses to medical students of all ages, it is necessary for researchers, field experts, and practitioners to search for more effective methods of reducing negative attitudes related to and associated with stigmatizations.

Proposed solutions and recommendations

Corrigan et al. [44] tested three proposed methods to alter attitudes towards various mental health problems. These methods were education to help change misconceptions, contact to mediate the views of society and suppressing stigma through protesting. The last strategy yielded minimal results. However, education was successful in enforcing the concept that mental disorders are not a life sentence but can be cured by psychiatric methods. Still, this method was not effective in changing views on patient stability and controllability.

Contact with patients was overall the most successful strategy. It entailed learning about patients as persons before their illnesses and also interacting with them. In the scope of things, this produced results that showed controllability and stability. The role of experiences gained from childhood, in society and within health service institutions as well as among professional peer groups has been shown to reshape negative beliefs that were held prior to these experiences. The responsibility for showing society that mentally ill patients can retain their capacities and for demanding respect for their rights lies with medical professionals, modeling this responsibility by changing their own behaviors [22].

The health professional should encourage as much autonomy for the patient as the patient's faculties will allow. The culture of indiscriminate sedation (because of the assumption that the patient will be violent) should be scrutinized, and more stringent guidelines must be created to govern the administering of sedatives [22]. McDaid recommended the launching of services that would better meet the needs of patients as one way of mitigating stigma towards them. He proposed the provision of cash to enable the person to purchase services they require including stays in institutions. He also proposed the dissemination of more information to enable people to know when and where to access mental health care. The use of advanced directives has also been recommended. Here, the person, when healthy, lays out specific instructions as to where and how they prefer to be treated in case they become mentally incapacitated.

Programs to counter the misconceptions of the public on mental health services should be initiated. These may include awareness campaigns, support groups for families and patients, and introduction of basics of mental health in medical education curricula, ensuring that as many students as possible come into contact with patients with mental illness. In addition, improved vigilance should be shown in providing constant evaluation and review of patient-doctor relationships. Legislation could be passed to set guidelines on the enrollment of the mentally ill in educational and health institutions as well as employment [45].

The approach of using psychiatrists as role models or frontrunners in anti-stigma campaigns cannot be realized without action. Psychiatrists must face the grim fact that their attitudes do not contrast sharply with those of the general public, and thus, they should broaden their knowledge about stigma and discrimination towards people with mental illnesses.

Limitations in the reviewed literature

The major limitations of these studies were their subjective nature. Most of the respondents may have answered in politically correct ways rather than telling the researcher exactly what they feel. The use of questionnaires with multiple-choice questions, though easy to analyze, raises concerns about their ability to capture all of the views that are held by the sample population. Some researchers reported that expected sample sizes shrunk because of respondents' unwillingness to participate [46]. Although enlisting the opinions of mentally ill patients is recommended, this can in itself be a problem because of the disease status. In addition, there were no mechanisms to undertake pilot and exploratory studies [22].

Another limitation of most of these studies is their comparatively small sample of health workers working within one mental health firm. This limits the transferability of the findings to a global perspective; it may also affect the credibility of any generalizing to other similar settings. However, samples from different countries may well have positively contributed to the potential for generalization of their various attributes to wider applications.

Conclusion

As in excess of 47 studies have shown, there are varying types and reasons for the existence of both positive and negative attitudes in mental health care. The seriousness, however, of the findings relative to negative attitudes, comes from the seriousness of society's stake in outcomes and the real potential for harm. Roughly two-thirds of these studies indicate the destructiveness of such attitudes to public health efforts, especially getting people to seek mental health professionals' services when necessary. Also indicated are

likely detrimental effects to the administration of psychiatric treatments in environments wrought with inequalities.

The depth to which society at large has set beliefs on the viability and suitability of mental health care is evident. These staid beliefs can make it difficult to assess the real burden of mental illness as many are unwilling to be declared mentally ill or indeed, too frightened of such an outcome. This raises questions as to why modern society specifically discriminates against mental illness, treating "it" as mythological, even as it exists in the same realm as other physical diseases, professionally regarded as pathological in nature.

The work here for researchers is clear. They need to find the base reasons why not only healthcare providers but a majority of society is permeated with negativity towards patients with mental illness. In conjunction with health professionals, researchers need to pursue study of methods for putting existing societal structures into better use and adapting reliable regimens for tackling the discomfort that these patients face. Health-seeking behaviors might be more thoroughly assessed to develop outreach programs that enable people to conveniently seek the medical intervention they need in venues and settings that allow for their comfort and reasonable privacy.

References

1. Corrigan PW, Markowitz FE, Watson AC (2004) Structural levels of mental illness: Stigma and discrimination. Schizophrenia Bulletin 20: 481-491.

2. Wahl OF (2003) News media portrayal of mental illness. American Behavioral Scientist 46: 1594-1600.

3. Centers for Disease Control and Prevention (2012) Attitudes toward mental Illness. Accessed on: March 15, 2018.

4. Tehrani E, Borg L, Krussel J, Munk-Jorgensen P (1996) Quitting on psychiatric treatment: A prospective study of a first-admission cohort. Acta Psychiatrica Scandinavica 94: 266-271.

5. Charbonneau M (2007) Stigma and discrimination-as articulated by mental health specialists. Mood Disorders Society of Canada.

6. McDaid D, Maxine L, Patel R (2008) Attitudes to psychosis: health professionals. Counteracting the stigmatization and discrimination of persons with mental health complications in Europe. Luxembourg: European Commission, pp: 1-20.

7. Antonio R, Benson JR, Brunt C, Connors AT (2012) Eliminating stigma in Healthcare Organizations. Available from: www.mhlac.org/Docs/Eradicating_Stigma_4_13.pdf Accessed on: March 15, 2018.

8. Cechnicki A, Bielańska A, Angermeyer MC (2011) Expected and experienced stigma among persons with schizophrenia: its nature and its correlations. Social Psychiatry and Psychiatric Epidemiology 46: 643-650.

9. Caldwell TM, Jorm AF (2001) Mental health nurses' beliefs about likely outcomes for people with schizophrenia or depression: A comparison with the public and other healthcare professionals. Australian and New Zealand Journal of Mental Health Nursing 10: 42-54.

10. Jorm AF, Korten AE, Jacomb PA, Rodgers BR, Pollitt P, et al. (1997) Effectiveness of interventions for mental disorders: beliefs of health experts compared with the populace. The British Journal of Psychiatry 171: 233-237.

11. Lauber C, Anthony M, Ajdacic-Gross V, Rössler W (2004) What about psychiatrists' attitude to mentally ill people? European Psychiatry 19: 423-427.

12. Reavley NJ, Mackinnon AJ, Morgan AJ, Jorm AF (2014) Stigmatising attitudes towards people with mental disorders: A comparison of Australian health professionals with the general community. The Australian and New Zealand Journal of Psychiatry 48: 433-441.

13. Sriram TG, Jabbarpour YM (2005) Are mental health professionals immune to stigmatizing beliefs? Psychiatric Services 56: 610.

14. White A, Shiralkar P, Hassan T, Galbraith N, Callaghan R (2006) Barriers to mental healthcare for psychiatrists. Psychiatric Bulletin 30: 382-384.

15. Bell JS, Aaltonen SE, Airaksinen MS, Volmer D, Gharat MS, et al. (2010) Determinants of mental health stigma among pharmacy students in Australia, Belgium, Estonia, Finland, India and Latvia. The International Journal of Social Psychiatry 56: 3-14.

16. Corker E (2001) Stigma caused by psychiatrists. The British Journal of Psychiatry: The Journal of Mental Science 178: 379.

17. Lauber C, Nordt C, Braunschweig C, Rössler W (2006) Do mental health professionals stigmatize their patients? Acta Psychiatrica Scandinavica 113: 51-59.

18. Rao H, Mahadevappa H, Pillay P, Sessay M, Abraham A, et al. (2009) A study of stigmatized attitudes towards people with mental health problems among health professionals. Journal of Psychiatric and Mental Health Nursing 16: 279-284.

19. Rüsch N, Angermeyer MC, Corrigan PW (2005) Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. European Psychiatry 20: 529-539.

20. Schulze B, Angermeyer MC (2003) Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. Social Science and Medicine 56: 299-312.

21. Harangozo J, Reneses B, Brohan E, Sebes J, Csukly G, et al. (2013) Stigma and discrimination against persons with schizophrenia connected to medical services. The International Journal of Social Psychiatry 60: 359-366.

22. Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M (2009) Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. The Lancet 373: 408-415.

23. Thornicroft G, Rose D, Kassam A (2007) Discrimination in health care against people with mental illness. International Review of Psychiatry 19: 113-122.

24. Thornicroft G, Rose D, Mehta N (2010) Discrimination against people with mental illness: What can psychiatrists do? Advances in Psychiatric Treatment 16: 53-59.

25. Hugo M (2001) Mental health professionals' attitudes towards people who have experienced a mental health disorder. Journal of Psychiatric and Mental Health Nursing 8: 419-425.

26. Hansson L, Jormfeldt H, Svedberg P, Svensson B (2013) Mental health professionals' attitudes towards people with mental illness: Do they differ from attitudes held by people with mental illness? The International Journal of Social Psychiatry 59: 48-54.

27. Chaplin R (2000) Psychiatrists can cause stigma too. The British Journal of Psychiatry: The Journal of Mental Science 177: 467.

28. Nordt C, Rössler W, Lauber C (2006) Attitudes of mental health professionals toward people with schizophrenia and major depression (english). Schizophr Bull 32: 709-714.

29. Thompson-Brenner H, Franko DL, Satir DA, Herzog DB (2012) Clinician responses to patients with eating disorders: An appraisal of the literature. Psychiatric Services 63: 73-78.

30. Murray MG, Steffen JJ (1999) Attitudes of case managers toward people with severe mental illness. Community Mental Health Journal 35: 505-514.

31. Jones DR, Macias C, Barreira PJ, Fisher WH, Hargreaves WA, et al. (2004) Prevalence, severity, and co-occurrence of chronic physical health problems of persons with serious mental illness. Psychiatric Services 55: 1250-1257.

32. McCreadie RG, Stevens H, Henderson J, Hall D, McCaul R, et al. (2004) The dental health of people with schizophrenia. Acta Psychiatrica Scandinavica 110: 306-310.

33. Phelan M, Stradins L, Morrison S (2001) Physical health of people with extreme mental illness. BMJ 322: 443-444.

34. McCreadie RG (2003) Diet, smoking and cardiovascular risk in people with schizophrenia Descriptive study. The British Journal of Psychiatry 183: 534-539.

35. McKay D (2000) Stigmatizing pharmaceutical commercials. The British Journal of Psychiatry 177: 467-468.

36. Loch AA, Lawson FL, Hengartner MP, Rössler W, Gattaz FB, et al. (2013) Stigma toward schizophrenia: do all psychiatrists act the same? Latent profile examination of a national model of psychiatrists in Brazil. BMC Psychiatry 13: 92.

37. Schulze B (2007) Stigma and mental health professionals: A review of the evidence on an intricate relationship. International Review of Psychiatry 19: 137-155.

38. Hassan TM, Ahmed SO, White AC, Galbraith N (2009) A postal review of doctors' attitudes to becoming mentally ill. Clinical Medicine 9: 327-332.

39. Filipic I, Pavicic D, Filipcic A, Hotujac L, Begic D, et al. (2003) Attitudes of medical staff towards the psychiatric label "schizophrenic patient" tested by an anti-stigma questionnaire. Collegium Antropologicum 27: 301-307.

40. Chikaodiri AN (2009) Attitude of health personnel to the care of psychiatric patients. Annals of General Psychiatry 8: 19.

41. Latalova K, Kamaradova D, Prasko J (2014) Perspectives on perceived stigma and self-stigma in adult male patients with depression. Neuropsychiatric Disease and Treatment 10: 1399.

42. Pădurariu M, Ciobîcă A, Persson C, Ştefănescu C (2013) Self-stigma in psychiatry: moral and bio-psycho-social standpoints. Revisit Romana de Bioetica 9: 76-82.

43. Yadav T, Kataria D, Arya K (2012) Effect of psychiatric education and teaching on attitude of medical undergraduate students towards the mentally ill: a comparative scrutiny. Ind Psychiatry J 21: 22-31.

44. Corrigan PW, River LP, Penn DL, Uphoff W, Lundin R, et al. (2001) Three approaches for shifting attributions about severe mental illness. Schizophrenia Bulletin 27: 187.

45. Corrigan PW, Watson AC (2002) Understanding the impact of stigma on people with mental illness. World Psychiatry 1: 16.

46. Wahl OF (1999) Mental health consumers' experience of stigma. Schizophrenia Bulletin 25: 467.