Main Issues of Pedagogy and Psychology
e-ISSN 1829-1295 (Online)
miopap.com/en

Volume 4 · Issue 2 · 2026
Pages 1392–1403

Stigma Associated with Mental Disorders: The Interplay Between Social Representations and Individual Suffering

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Received: 18/02/2026 | **Accepted:** 27/08/2026 | **Published:** 21/10/2026

ABSTRACT

Stigma associated with mental disorders extends beyond negative attitudes toward mental illness to encompass social and psychological processes that affect individuals' identities, self-esteem, social relationships, and willingness to seek professional help. This phenomenon is shaped by multiple interacting factors, including social representations of mental disorders, prevailing stereotypes, discriminatory and exclusionary practices, and the internalization of negative judgments directed at people experiencing mental health conditions.

This study aims to examine stigma associated with mental disorders from an integrated theoretical perspective combining social psychology and clinical psychology. It explores the conceptual foundations of stigma, analyzes the relationship between social representations and self-stigma, and examines the potential implications of stigma for mental health and help-seeking behavior. The study adopts a descriptive-analytical approach based on a review of selected theoretical and empirical literature on stigma and mental health.

The value of this integrative perspective lies in understanding stigma as a phenomenon rooted in a specific sociocultural context that may, in turn, become an internal psychological experience affecting psychological distress, adaptation, and engagement with mental health services. The study concludes that reducing stigma requires moving beyond general awareness-raising initiatives toward comprehensive interventions addressing social representations, discriminatory practices, self-stigma, and barriers to accessing mental health care.

Keywords: Social stigma; mental disorders; social representations; self-stigma; psychological distress; help-seeking behavior.

Introduction

The consequences of mental disorders are not limited to the symptoms experienced by individuals or the difficulties these symptoms may cause in everyday functioning and social adjustment. They may also extend to the ways in which society perceives individuals and the ways in which individuals understand themselves in light of the social beliefs and judgments associated with their mental health conditions. People experiencing mental disorders may encounter rejection, the minimization of their suffering, or doubts about their ability to assume responsibilities. They may also face discrimination in certain areas of social and professional life. Thus, alongside its clinical dimensions, the experience of psychological distress is embedded in a social context that may intensify its challenges and influence opportunities for adaptation and recovery.

Stigma refers to a social process through which a negative meaning is attached to a particular characteristic or condition, distinguishing those associated with it from others and reinforcing stereotypes about them. This process

may result in marginalization or a diminished social status. Stigma does not arise merely because an individual differs from others or is assigned a particular label. Rather, it develops through the interaction of labeling, stereotyping, symbolic separation between groups, and power relations that enable these elements to translate into discriminatory practices (Link & Phelan, 2001, pp. 364–365).

In the field of mental health, stigma is particularly significant because certain beliefs persist that associate mental disorders with personal weakness, loss of control, dangerousness, or an inability to integrate into society. These beliefs may influence how family members and the wider social environment treat the person concerned. They may also become incorporated into the individual's self-perception when negative societal judgments about mental disorders are internalized. Consequently, stigma is no longer merely an attitude expressed by others; it may become an internal psychological experience affecting self-esteem, perceived competence, and the sense of belonging (Corrigan & Watson, 2002, pp. 16–17).

This highlights the importance of integrating social psychology and clinical psychology. Social psychology helps explain how social representations emerge, how stereotypes circulate, and how exclusion and discrimination operate. Clinical psychology, in turn, provides a framework for examining how these experiences affect an individual's psychological state, understanding of their distress, emotional and behavioral responses, and decisions concerning help-seeking. Combining these perspectives makes it possible to move beyond reductionist explanations that attribute stigma solely to a lack of knowledge or examine psychological distress independently of the social context in which the individual lives.

Against this background, the present study offers a theoretical and analytical examination of stigma associated with mental disorders by linking social representations to the mechanisms and psychological consequences of stigma. It also highlights the importance of this relationship for understanding barriers that may limit access to mental health services.

1. Research Problem

Despite advances in scientific knowledge about mental disorders and the expansion of diagnostic, therapeutic, and support services, negative judgments associated with these conditions remain present in social discourse and everyday practices. Such attitudes may manifest in reluctance to disclose psychological distress, fear of others' reactions, avoidance of professional assistance, or the tendency to perceive an individual primarily through a diagnosis rather than as a person with distinctive characteristics, abilities, and rights.

These manifestations cannot be understood solely in terms of clinical symptoms. They are also related to the meanings society assigns to mental disorders, the stereotypes developed about those who experience them, and the extent to which such stereotypes become self-directed judgments that individuals adopt when interpreting their own experiences. The literature indicates that stigma is associated with multiple barriers to seeking psychological help, although the strength and nature of this relationship vary according to the contexts, individuals, and types of barriers examined (Clement et al., 2015, p. 18).

Accordingly, the central research question is:

How does the interaction between social representations of mental disorders and the mechanisms of stigma contribute to shaping individuals' psychological distress?

This question gives rise to the following subquestions:

1. What is meant by stigma associated with mental disorders, and what are its principal dimensions and components?
2. How do social representations and stereotypes contribute to the production and perpetuation of stigma?
3. How can stigma move from the level of social judgments to that of self-stigma?
4. What are the main potential psychological and social consequences of stigma?
5. How may stigma influence decisions to seek psychological help and continued engagement with mental health services?

2. Objectives of the Study

The study aims to:

- Clarify the concept of stigma associated with mental disorders and distinguish its social and individual dimensions.
- Analyze the role of social representations and stereotypes in shaping judgments about mental illness.
- Explain the relationship between public stigma and self-stigma while accounting for differences in their levels and underlying mechanisms.
- Identify the principal potential psychological and social consequences of stigma for self-esteem, identity, and social relationships.
- Examine the relationship between stigma, psychological help-seeking, and the use of mental health services.
- Propose theoretical and practical foundations for stigma reduction through the integration of social and clinical psychological perspectives.

3. Significance of the Study

The theoretical significance of this study lies in its treatment of stigma as a multidimensional phenomenon that cannot be explained solely by individual characteristics or social attitudes. Understanding stigma requires examining the social conditions that produce stereotypes and give them their influence, alongside the ways individuals receive, respond to, or resist these judgments.

The practical significance of the study lies in the potential application of its theoretical analysis to the development of psychological interventions and awareness initiatives, the promotion of respectful treatment of people experiencing mental disorders, and the improvement of relationships between recipients of mental health services and care providers. This perspective also draws attention to the social and psychological barriers that may prevent individuals from seeking help, rather than reducing these barriers to a lack of awareness or motivation on the part of the individual.

4. Research Methodology

The study adopts a descriptive-analytical approach in a theoretical form, based on reviewing and analyzing selected foundational literature and research addressing the concept of stigma, mental health-related stigma, self-stigma, and the relationship between stigma and help-seeking. The analysis draws on major theoretical frameworks, including the conceptualization of stigma as an interconnected social process, approaches examining stigma in relation to identity, and literature addressing the effects of stigma on psychological help-seeking behavior.

The study does not claim to provide new empirical findings or establish direct causal relationships. Rather, its purpose is to organize existing theoretical knowledge and examine the conceptual connections among relevant ideas in order to develop an integrated understanding of the phenomenon. Furthermore, the selection of foundational literature should not be equated with a comprehensive systematic review of all published studies, a limitation that should be considered when interpreting the scope of the conclusions.

5. Conceptual Framework of Stigma Associated with Mental Disorders

5.1. The Concept of Stigma

The concept of stigma is associated with Erving Goffman's work on stigma and his analysis of social labeling and the devaluation of individuals. In his book Stigma: Notes on the Management of Spoiled Identity, Goffman (1963) examined how certain attributes may undermine an individual's eligibility for full social acceptance. Such attributes may be physical, biographical, or relational, leading others to associate the individual with discrediting characteristics or socially disapproved identities (Chabou, 2017, p. 347).

Goffman conceptualized stigma as an attribute that, within a particular social context, may diminish an individual's social value and undermine recognition of that person as an accepted member of the community. The importance of this perspective lies in its treatment of stigma not as an inherent or fixed characteristic of the individual, but as a phenomenon linked to the meaning that the social environment assigns to a particular attribute and the expectations

that shape subsequent social interactions (Goffman, 1963, p. 63).

Extending this conceptualization, Link and Phelan (2001) explained that stigma involves more than labeling or forming negative impressions. It comprises a series of interconnected processes, including labeling, associating labeled groups with stereotypes, establishing symbolic boundaries between groups, and producing status loss or discrimination within social power relations .(Link & Phelan, 2001, pp 366–369)

On this basis, stigma associated with mental disorders can be operationally defined in the present study as a multidimensional social and psychological process through which people experiencing mental health conditions are assigned negative labels and associated with stereotypes that may lead to social distancing, diminished status, discrimination, and, in some circumstances, the internalization of these negative judgments.

5.2. Mental Health-Related Stigma and Its Distinctive Characteristics

Stigma associated with mental health has particular characteristics arising from the meanings attributed to mental disorders and the beliefs surrounding the people who experience them. These beliefs may associate mental illness with weakness, dangerousness, unpredictability, loss of control, or an inability to fulfill social responsibilities.

Such perceptions may shape how individuals experiencing mental disorders are treated within their families, communities, educational settings, and workplaces. They may also influence their opportunities for social participation and access to support.

An important characteristic of mental health-related stigma is that it may operate at both the interpersonal and institutional levels. At the interpersonal level, it may appear in rejection, avoidance, disparaging remarks, or doubts about an individual's abilities. At the institutional level, it may be reflected in practices or arrangements that restrict opportunities, undermine equal treatment, or create barriers to obtaining appropriate care

Stigma may also affect individuals' self-perceptions when they internalize negative stereotypes associated with mental disorders. Nevertheless, exposure to stigmatizing attitudes does not necessarily lead to self-stigma. Individuals differ in how they interpret, resist, or incorporate social judgments into their understanding of themselves. . (Corrigan & Watson, 2002, p18)

Therefore, mental health-related stigma should be understood as a phenomenon shaped by the interaction between social attitudes, interpersonal experiences, institutional practices, and individual interpretations. This perspective helps explain why stigma may have different consequences across individuals and contexts.

6. Social Representations and Their Role in the Construction of Stigma

Social representations refer to shared systems of meanings, beliefs, and knowledge that develop within groups and help individuals interpret phenomena and organize their attitudes toward them. These representations are not formed exclusively from scientifically accurate information. They may also incorporate personal experiences, cultural traditions, media discourse, and everyday interactions. Consequently, they can change over time, but they may also sustain generalizations or inaccurate judgments.

In the context of mental disorders, social representations may revolve around concepts such as madness, weakness, danger, or loss of control. Some of these concepts may be applied indiscriminately, without accounting for differences among disorders, variations in their manifestations, or differences in severity. When such perceptions become widely circulated and socially accepted, they may influence how people experiencing mental disorders are received and shape others' expectations regarding their behavior and abilities.

The framework proposed by Link and Phelan (2001) helps explain how social perceptions may move from the level of ideas and labels to the level of social consequences. Labeling alone does not necessarily produce discrimination. Rather, its effects emerge when a label becomes associated with a negative stereotype, serves as a basis for separating individuals or groups, and operates within social power relations that produce inequalities in status and opportunities (Link & Phelan, 2001, p371–373).

This analysis demonstrates why stigma reduction cannot rely solely on providing information about mental disorders. Although accurate knowledge is important, it may not be sufficient to change established attitudes or eliminate discriminatory practices. Interventions must also address the social meanings attached to mental illness, the stereotypes reinforced through everyday interactions, and the institutional conditions that may sustain exclusion.

Social representations may also influence the ways individuals interpret their own psychological experiences. When negative beliefs about mental disorders are widely accepted, people experiencing such conditions may anticipate rejection or fear that disclosure will affect their social standing. Under certain circumstances, they may internalize these beliefs and incorporate them into their self-perceptions.

However, the relationship between social representations and self-stigma is neither automatic nor inevitable. Individuals may challenge prevailing stereotypes, draw on supportive relationships, or develop alternative understandings of their experiences. Accordingly, the analysis of stigma requires attention both to the social processes through which negative meanings are produced and to the individual and contextual factors that influence how those meanings are received.

7. Dimensions of Stigma Associated with Mental Disorders

Before examining the dimensions of stigma associated with mental disorders, it is important to introduce the theoretical model proposed by Corrigan et al., which explains the progression of self-stigma through four distinct but interrelated levels.

Level 1: Awareness of Stereotypes. At this level, individuals who belong to a stigmatized group become aware of the negative stereotypes held by society about their group. For example: “I am aware that people perceive me as less competent.”

Level 2: Agreement with Stereotypes. At this level, individuals not only recognize the existence of negative stereotypes but also agree with the stereotypical beliefs directed toward their stigmatized group. For example: “I agree with the belief that people like me are less competent, and this makes me feel uncomfortable.”

Level 3: Self-Application of Stereotypes. At this level, individuals apply the negative stereotypes associated with their group to themselves, incorporating these beliefs into their self-perception. For example: “Because I have this condition, I am less competent.”

Level 4: Harmful Consequences. At this level, the internalization of negative stereotypes may result in adverse psychological outcomes, such as diminished self-esteem and reduced self-efficacy. For example: “My self-esteem has been negatively affected because I perceive myself as less competent.” (Merakeb & Ben Khaled, 2023, p. 172)

7.1. Public or Social Stigma

Public stigma refers to the negative stereotypes and attitudes held by some members of society toward people experiencing mental disorders. These attitudes may be accompanied by a willingness to distance oneself from them, refuse interaction with them, or question their abilities. Public stigma may appear in everyday discourse, family and social relationships, or certain institutional practices.

Negative attitudes do not always translate into actual discrimination. However, they may create the conditions for discrimination or provide a justification for it when they become decisions or practices that deprive individuals of opportunities or rights available to others. It is therefore important to distinguish between negative beliefs, emotional responses, and discriminatory behavior while recognizing that these dimensions may interact.

This distinction is important because stigma cannot be adequately assessed by measuring explicitly expressed attitudes alone. Assessment should also consider actual behavior, the experiences of people who have encountered rejection or exclusion, and the institutional conditions that may allow discrimination to persist (Link & Phelan, 2001, p. 375).

7.2. Self-Stigma or Internalized Stigma

Self-stigma refers to the process through which individuals internalize certain stereotypes and negative judgments associated with mental disorders and subsequently direct them toward themselves or use them to interpret their abilities and personal worth. This may be expressed in the belief that one is less capable than others, unworthy of respect, or less likely to be accepted socially or professionally because of one's mental health condition.

Self-stigma differs from merely knowing that negative social attitudes exist. An individual may recognize that some people hold prejudiced views about mental disorders without accepting those views or applying them to themselves. Self-stigma, by contrast, involves some degree of internalization of stereotypes and may be associated with lower self-esteem or a reduced sense of personal agency.

The systematic review and meta-analysis conducted by Livingston and Boyd (2010) identified associations between internalized stigma and several psychological and social outcomes among people experiencing mental disorders. The strength of these associations varied according to the variables examined and the research contexts. These findings support the importance of considering self-stigma as a construct that is relatively distinct from general public attitudes.

Nevertheless, not all individuals internalize negative judgments to the same extent, and exposure to stigma does not necessarily result in self-stigma. Factors such as social support, critical awareness of stereotypes, positive experiences with professionals, and a sense of belonging may help reduce the influence of these judgments on an individual's self-concept.

7.3. Anticipated Stigma and Actual Discrimination

Stigma may also take the form of anticipated rejection or devaluation if individuals disclose their mental health conditions or seek professional help. This expectation may lead them to conceal their distress, avoid disclosure, or postpone consulting professionals, even when care is needed.

A distinction should be made between anticipating discrimination and actually experiencing it. Individuals may expect rejection on the basis of previous experiences or prevailing social beliefs, whereas others may encounter direct discriminatory practices. In both situations, fear of social consequences may influence decisions about disclosure and help-seeking. However, the nature and extent of this influence must be understood in relation to the individual's circumstances and social context.

Clement et al. (2015) emphasized that mental health-related stigma is one of several barriers associated with help-seeking, alongside personal, social, and organizational obstacles. Reluctance to seek treatment should therefore not be explained by stigma alone, but rather understood in relation to a range of potentially interacting factors (Clement et al., 2015, p 12–16,).

8. From Social Representations to Self-Stigma: A Psychosocial Perspective

An integrative approach helps explain stigma as a process that may operate across several interconnected levels. At the societal level, groups circulate stereotypes about mental disorders through everyday comments, family expectations, media representations, and certain institutional practices. At the level of social interaction, individuals may encounter direct judgments or feel that others reduce them to their diagnoses. At the individual level, they may accept some of these judgments or reinterpret themselves in their light.

This process may follow a hypothetical trajectory beginning with exposure to a negative stereotype, followed by recognition that the stereotype is associated with the group to which the individual belongs, and then the internalization and application of some of its implications to the self. However, this trajectory is neither inevitable nor uniform. Individuals may reject stereotypes, reinterpret them, or draw on social support that prevents them from becoming self-directed judgments.

Corrigan and Watson (2002) explained that the effects of stigma vary according to how individuals respond to stereotypes and that awareness of negative social attitudes does not necessarily lead to their internalization. This distinction helps explain why stigma may affect people differently even when they face relatively similar social circumstances (Corrigan & Watson, 2002, p 19)

From a clinical psychology perspective, these experiences become particularly relevant when they influence how individuals understand their distress, perceive their competence, or express their psychological needs. From a social psychology perspective, these experiences remain connected to the meanings that society assigns to mental disorders and the social status attributed to those classified as having them.

Understanding self-stigma therefore requires consideration of the interaction between the external social context and the individual's internal interpretations, without reducing the phenomenon to either dimension alone.

9. Psychological and Social Consequences of Stigma

9.1. Self-Esteem and Perceived Competence

Self-stigma may be associated with reduced self-esteem and a diminished sense of competence, particularly when individuals adopt beliefs that portray mental disorders as evidence of inadequacy, failure, or an inability to achieve personal goals. In such circumstances, self-evaluation may become less grounded in actual experiences and abilities and more strongly influenced by the judgments that the social environment attaches to people experiencing mental disorders.

The literature on internalized stigma identifies associations with a range of psychological and social outcomes, highlighting the importance of examining individuals' subjective experiences when studying the consequences of stigma. However, reduced self-esteem should not be regarded as an inevitable consequence of stigma, nor should a direct causal relationship be assumed in every case. The relationship may be influenced by symptom severity, social support, previous experiences, and living conditions (Livingston & Boyd, 2010, pp. 2158–2160).

9.2. Identity and Sense of Belonging

Stigma may affect the way individuals negotiate their personal identities in relation to the social labels associated with their mental health conditions. When others reduce a person to a diagnosis, the individual may feel that important aspects of their identity are overlooked and that their abilities, interests, and relationships receive less recognition than the diagnostic label.

Goffman's conceptualization of stigma is particularly relevant here because it illustrates how a single attribute may become dominant in others' perceptions of an individual, influencing social interactions and opportunities for recognition within a group (Goffman, 1963).

Nevertheless, having a mental health diagnosis does not necessarily mean that a person's identity is defined by it. Individuals may maintain their social roles and develop multiple identities that extend beyond their experiences of mental illness.

9.3. Family and Social Relationships

Family and social relationships may be affected by stigma when fear, embarrassment, or the belief that mental disorders should be concealed becomes widespread, or when individuals are treated as sources of shame or burdens on those around them. Such experiences may weaken communication, reduce social participation, or make it difficult for individuals to express their psychological needs.

Conversely, family and social support may play an important role in reducing isolation and helping individuals seek treatment and adapt to the demands of care. This does not mean that families are invariably sources of stigma or that social support automatically eliminates its effects. Family roles vary according to levels of knowledge, relationship dynamics, surrounding pressures, and the availability of resources and services.

A psychosocial analysis therefore requires examining stigma within the network of relationships in which individuals live. It should avoid placing sole responsibility for adaptation on the individual or attributing the phenomenon exclusively to the family, independently of the wider cultural and institutional context.

9.4. Additional Psychological Distress

Stigma may add experiences of fear, shame, rejection, or isolation to the distress associated with an underlying mental disorder. This suggests that, in addition to the symptoms or difficulties that prompted the individual to seek help, they may face social pressures arising from the ways others interpret their condition.

The concept of stigma helps explain this additional burden. However, it does not justify the conclusion that stigma accounts for every manifestation of psychological distress or determines the course of a disorder. Psychological distress is influenced by multiple biological, psychological, and social factors and must be assessed clinically in light of each individual's circumstances.

The importance of this analysis lies in ensuring that the potential effects of social judgments and discrimination on individuals' experiences, coping resources, and ability to benefit from care are not overlooked (Rüsch et al., 2005, pp. 165–166).

10. Stigma and Psychological Help-Seeking

Psychological help-seeking is a behavior influenced by multiple factors, including perceived need for assistance, attitudes toward treatment, trust in professionals, service availability and accessibility, and social beliefs about mental illness. Stigma may constitute one of the barriers that make individuals reluctant to disclose their distress or fearful that seeking help will negatively affect how others perceive them.

Clement et al. (2015), in their systematic review, demonstrated that mental health-related stigma was associated with barriers to help-seeking across a range of qualitative and quantitative studies. However, the studies varied in their approaches to measuring stigma and in the outcomes examined. These findings support the importance of recognizing stigma as a relevant factor without treating it as the sole explanation for failure to seek care (Clement et al., 2015, pp 21–25)

Self-stigma is particularly relevant in this context when individuals believe that seeking psychological help is a sign of weakness or incapacity, or fear that disclosing their difficulties will diminish their personal worth. Vogel et al. (2006) examined self-stigma associated with seeking psychological help and developed an instrument to measure this construct, contributing to research on the relationship between negative attitudes toward help-seeking and individuals' self-perceptions (Vogel et al., 2006, pp. 326–334).

At the same time, reluctance to seek treatment cannot be explained solely by fear of stigma. It may also be associated with the cost of services, limited accessibility, a shortage of professionals, low levels of trust in institutions, or the belief that the problem will resolve itself. A multifactorial perspective is therefore necessary when analyzing help-seeking behavior, with attention to the distinction between psychological, social, and organizational barriers.

Furthermore, reducing stigma cannot be achieved simply by encouraging individuals to seek help. It also requires accessible services, confidentiality, respectful treatment, and improved experiences within therapeutic institutions. Corrigan et al. (2014) discussed the effects of stigma on mental health service utilization and engagement, emphasizing the importance of understanding negative attitudes as one of the factors influencing relationships with mental health services (Corrigan et al., 2014, pp. 41–57).

11. Toward an Integrative Approach Combining Social Psychology and Clinical Psychology

Integrating social psychology and clinical psychology makes it possible to develop a broader understanding of stigma associated with mental disorders because the phenomenon emerges at the intersection of social meanings and individual experiences. The social psychological perspective explains how categories and stereotypes are produced and circulated, while also helping to analyze discrimination and the social relations that sustain inequalities in status and opportunities. The clinical psychological perspective, in turn, helps explain how these experiences affect self-perception, emotional responses, behavior, and therapeutic needs.

Theoretically, this integrative approach can be organized around three interconnected levels.

First: The sociocultural level. This includes prevailing social representations of mental disorders, the language used to describe them, media portrayals, and family, community, and institutional attitudes. Analysis at this level seeks to understand how negative judgments are produced and disseminated rather than treating them merely as isolated individual attitudes.

Second: The interactional and relational level. This concerns the experiences individuals encounter in their interactions with others, including rejection, avoidance, overprotection, and being reduced to a diagnosis. This level makes it possible to examine how general social perceptions become everyday experiences that influence acceptance, belonging, and trust in others.

Third: The individual and clinical psychological level. This concerns how individuals interpret these experiences, the extent to which they adopt negative judgments, and the potential consequences for self-esteem, perceived competence, and willingness to seek help. This level requires individualized assessment that takes account of personal history and psychological and social resources rather than assuming that everyone exposed to stigma responds in the same way.

These levels should not be understood as fixed stages or as a linear process that necessarily occurs in every individual. Rather, they are analytical levels that may interact in different ways. Social representations may shape

everyday relationships, while individual experiences may reinforce existing attitudes or encourage resistance to them. Positive therapeutic experiences may also help individuals reconsider negative beliefs about mental disorders.

This interpretation is consistent with approaches that conceptualize stigma as a phenomenon involving cognitive, emotional, behavioral, and social components. It also underscores the need to move beyond explanations that attribute the problem exclusively to a lack of knowledge or to the psychological characteristics of the individual (Rüsch et al., 2005, pp. 167–169).

12. Prospects for Reducing Stigma Associated with Mental Disorders

Reducing stigma requires interventions at multiple levels that address its different sources and consequences. General awareness-raising initiatives alone are insufficient if the conditions that sustain stereotypes or translate them into discriminatory practices remain unaddressed.

12.1. Promoting Scientific Knowledge and Correcting Stereotypes

Scientific awareness is an important means of addressing inaccurate information about mental disorders, provided that information is presented in a way that recognizes differences among disorders and the diversity of individual experiences.

Effective awareness initiatives should do more than explain symptoms or diagnostic categories. They should also emphasize that a diagnosis does not define an individual's entire identity and that people's abilities and support needs vary according to their circumstances and contexts.

Awareness campaigns should avoid reproducing stereotypes while attempting to correct them. They should use respectful language and avoid derogatory descriptions or generalizations that associate all mental disorders with a single set of characteristics.

12.2. Promoting Meaningful Direct Contact

Literature on anti-stigma interventions highlights the value of combining education with contact involving people with lived experience of mental disorders, provided that such contact takes place under appropriate conditions that respect privacy and ensure voluntary participation.

Thornicroft et al. (2016) reviewed evidence supporting the effectiveness of certain interventions designed to reduce stigma and discrimination, although outcomes varied according to the type of intervention, target population, and context (Thornicroft et al., 2016, pp. 527–530).

Direct contact should not be regarded as an automatic solution or a guarantee that prejudice will disappear. Its effectiveness depends on how the intervention is organized, the messages accompanying it, the opportunities participants have to reconsider previous attitudes, and the continuity of the intervention.

12.3. Supporting Individuals in Coping with Self-Stigma

From a clinical psychology perspective, care may involve helping individuals distinguish their mental health condition from their personal worth, critically examine negative beliefs they have adopted about themselves, and identify sources of support that strengthen their sense of competence and belonging.

Addressing self-stigma may form part of psychological intervention when relevant to the individual's needs, taking into account the nature of the problem, therapeutic goals, and the preferences of the person receiving care.

This does not mean making individuals responsible for eliminating the stigma imposed by society. Rather, it means providing them with resources to cope with its psychological consequences while simultaneously addressing the environments and practices that produce or reinforce discrimination.

12.4. Improving Professional and Institutional Practices

Addressing stigma within mental health services requires practices that respect service users' dignity, privacy, and autonomy while recognizing their right to participate in decisions concerning their care. Institutions should avoid reducing individuals to their diagnoses and work to remove barriers that prevent access to services or continued engagement with treatment.

This dimension is particularly important because individuals' experiences within institutions may strengthen their confidence in seeking help or increase their reluctance if they encounter

neglect, humiliation, or violations of confidentiality.

Corrigan et al. (2014) emphasized the importance of examining stigma in relation to access to and engagement with mental health care. This makes professional and therapeutic practices part of the broader discussion of how to reduce the social and psychological barriers that prevent people from benefiting from services ((Corrigan et al., 2014,pp63–68).

12.5. Developing Evidence-Based Interventions That Reflect Cultural Context

Anti-stigma programs require clear identification of their target populations, the attitudes or practices they seek to change, and the mechanisms through which the intervention is expected to operate. Their outcomes should then be evaluated using appropriate measures.

Evaluation should not be limited to knowledge or self-reported attitudes. Where possible, it should also examine actual behavior, the experiences reported by the people concerned, and the accessibility of mental health care.

Cultural and social contexts must also be considered when designing such programs. It should not be assumed that representations of mental disorders are identical across societies or that a single intervention will be equally effective in every setting. Evidence concerning anti-stigma interventions underscores the importance of selecting and evaluating approaches in relation to the target population and intended outcomes (Thornicroft et al., 2016, pp. 531–535).

13. Analytical Discussion

The theoretical analysis indicates that stigma associated with mental disorders cannot be understood merely as a negative attitude or a lack of knowledge. It is better conceptualized as a multidimensional process involving social classifications, stereotypes, everyday interactions, and individual psychological experiences.

The framework developed by Link and Phelan helps explain how these elements intersect with power relations and discrimination, while Goffman's conceptualization illuminates the effects of stigma on social status and identity in everyday interactions (Goffman, 1963; Link & Phelan, 2001).

The distinction between public stigma and self-stigma is also important. The presence of negative stereotypes in society does not mean that all individuals experiencing mental disorders will internalize them or be affected by them in the same way. This distinction demonstrates that the relationship between social context and individual experience is neither automatic nor inevitable. Protective factors, social support, and positive experiences may influence how individuals receive and respond to social judgments (Corrigan & Watson, 2002).

The analysis of the relationship between stigma and help-seeking further indicates that social and psychological barriers may influence when individuals seek care and their willingness to disclose their distress. However, these barriers do not operate independently of organizational, economic, and cultural factors. Failure to seek help may be associated with fear of stigma, but it may also result from difficulties accessing services, low levels of trust in providers, or a failure to recognize the need for assistance. Effective interventions should therefore address these factors collectively rather than interpreting help-seeking behavior through a single explanatory framework (Clement et al., 2015; Corrigan et al., 2014).

The principal contribution of the integrative approach lies in connecting processes occurring in the social environment with their potential implications for individual psychological experience. Stigma does not originate solely within the individual, nor do its consequences remain exclusively external. Under certain circumstances, social judgments may become a source of psychological distress or influence self-perception. At the same time, therapeutic experiences and social support may help mitigate some of these effects.

Nevertheless, this conclusion must be interpreted within the limitations of a theoretical study. The article does not provide empirical data that would establish the prevalence or magnitude of stigma in a particular society. Nor does it demonstrate that stigma affects all individuals in the same way or determine the contribution of each factor to psychological distress. Furthermore, the reviewed literature varies in its definitions and measurements of stigma and in the populations examined, requiring caution when generalizing the conclusions.

These limitations highlight the need for empirical research that takes local cultural contexts into account and examines social representations of mental disorders, experiences of enacted, anticipated, and self-stigma, and the

relationships between these dimensions and help-seeking behavior.

Qualitative studies may contribute to a deeper understanding of the meanings individuals assign to their experiences, while quantitative studies may examine associations between variables and estimate the prevalence of particular attitudes and experiences. Intervention studies could test the effectiveness of anti-stigma programs under specific conditions rather than assuming their effectiveness in advance.

Conclusion

The theoretical analysis demonstrates that stigma associated with mental disorders extends beyond explicitly expressed negative judgments. It is connected to the social representations through which communities understand mental disorders, the practices that may emerge from these representations, and the ways individuals may internalize some of these judgments and incorporate them into their self-perceptions. Potential consequences include diminished feelings of acceptance and belonging, changes in self-esteem, and reluctance to disclose psychological distress or seek professional help.

The integrative approach combining social psychology and clinical psychology emphasizes that understanding stigma requires connecting its social, interactional, and individual dimensions without reducing the phenomenon to a lack of knowledge or to the characteristics of people experiencing mental disorders. Social classifications and stereotypes emerge within specific social contexts, but they may produce internal psychological consequences when individuals adopt them or anticipate rejection and discrimination because of them.

Accordingly, stigma reduction requires a coordinated approach encompassing the dissemination of accurate scientific knowledge, the correction of stereotypes, the promotion of respectful human contact, support for individuals coping with self-stigma, and the improvement of professional and institutional practices that safeguard dignity, confidentiality, and access to care. It also requires further empirical and intervention research that accounts for cultural and social contexts and evaluates the effectiveness of proposed measures.

Ultimately, the goal of addressing stigma is not merely to change terminology or public discourse. It is to foster an understanding of mental disorders that preserves human dignity and does not reduce individuals to their diagnoses. Psychological distress should be approached as an experience that deserves understanding and care, rather than as a reason for exclusion or a diminished recognition of human worth.

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