psychiatry international

MDPI

*Article*

# Understanding Stigma in Mental Illness: A Novel Literature-Based Model of Development

**Jorge Magalhães Rodrigues *, Ana Sofia Cruz and Cristina Queirós**

FPCEUP—Faculty of Psychology and Education Sciences, University of Porto, 4200-135 Porto, Portugal
* Correspondence: jorgemrodrigues@outlook.pt

**Abstract:** The concept of stigma has evolved, initially denoting a mark of shame and now encompassing a broader range of negative societal perceptions. Cognitive-social models describe stigma as containing stereotypes, discrimination, and prejudice, with each dimension significantly impacting individuals' health, social interactions, and willingness to seek help. This study has the objective of exploring the main theories about stigma to propose a novel model that integrates these dimensions, illustrating their interactions and cumulative impact on individuals and their families. The model aims for a comprehensive understanding of stigma development in mental illness and provides valuable insights for developing targeted anti-stigma interventions, ultimately improving the lives of individuals with mental illness and their families.

**Keywords:** mental illness; self-stigma; vicarious stigma; family stigma; social stigma; structural stigma; theoretical model



Academic Editor: Ana Adan

Received: 6 August 2024
Revised: 19 December 2024
Accepted: 19 February 2025
Published: 22 February 2025

**Citation:** Rodrigues, J.M.; Cruz, A.S.; Queirós, C. Understanding Stigma in Mental Illness: A Novel Literature-Based Model of Development. *Psychiatry Int.* **2025**, *6*, 21. https://doi.org/10.3390/psychiatryint6010021



## 1. Introduction

Stigma has been a subject of study for many years. In the realm of sociology, Durkheim (1858–1917), the founding "father" of the discipline, recognized "deviance" as an inherent feature of all societies. He states that the moral interpretation of these "deviations" would determine which qualities and behaviors were considered more desirable than others [1]. This set the stage for a deeper exploration of stigma within the field of sociology.

Goffman (1922–1982), widely regarded as one of the most influential sociologists of the 20th century [2,3], further refined the concept of stigma. In his work [4], Goffman defined stigma as a state of being discredited or disqualified from full social participation. Moreover, he identified three primary categories: (1) Stigma Associated with Race, Ethnicity, Religion, or Ideology; (2) Stigma Associated with Physical Deformity; and (3) Stigma Associated with Mental Illness [5].

Lately, Link and Phelan [6] interpret stigma as the convergence of four distinct factors. First, there is the differentiation and labeling of various segments of society; next, the association of these labels with prejudices about those individuals; then, an ethic of antagonism is developed; and finally, these people are discouraged, placing them in a pejorative category of "them." It is this separation between "us" and "them" that is usually referred to as "difference", which then leads to disdain [7].

Therefore, stigma can be understood as a social dynamic closely linked to power relations, which enables the control of individuals who "deviate" from the norm and promotes labeling associated with this deviation [8].

Guided by the available literature, this study aims to explore the main theories about stigma in order to propose a novel model that integrates its dimensions, illustrating, also,

their interactions and cumulative impact on individuals and their families. The model aims to contribute to a comprehensive understanding of stigma development in mental illness, and to provide valuable insights for developing targeted anti-stigma interventions, ultimately improving the lives of individuals with mental illness and their families.

To achieve these aims, we will discuss the stigma surrounding mental health, focusing on micro- and macro-dimensions available in the literature. We will present a new model after examining these forms of stigma and conclude with strategies to combat it.

## 2. Stigma in Mental Illness

According to Erving Goffman [5], it is crucial to understand that the stigma associated with mental illness is a highly significant issue that requires thorough study and deeper exploration due to its profound impact on society.

Outlined according to cognitive-social models, stigma has been described as encompassing stereotypes, discrimination, and prejudice [9]. These elements are also identified and detailed in the literature concerning mental illness [10–13]. However, beyond these dimensions, others are essential for a comprehensive understanding of the phenomenon. Thus, Corrigan [14] proposes three dimensions: social stigma, self-stigma, and label avoidance, which can be analyzed according to two constructs aiming to delineate their impact on the health of individuals with mental illness: cognitive (prejudice/stereotype) and behavioral (discrimination).

The cognitive construct focuses on beliefs, attitudes, and stereotypes about individuals with mental illness, whereas the behavioral concept relates to actions and behaviors resulting from stigma [14].

Building on this framework, it is essential to delve into the specific dimensions of social stigma, self-stigma, and label avoidance. These dimensions provide a more nuanced understanding of stigma's impact on individuals with mental illness and are crucial for comprehending the broader social context of stigmatization.

### *2.1. Social Stigma*

Social stigma refers to the discriminatory treatment applied by the population, which, in general, adheres to the "stereotyping" of mental illness. According to Corrigan [14], the most concerning forms of discrimination are avoidance and withdrawal.

It is worth noting that since the earliest civilizations, there has been a tendency to avoid or distance individuals with mental illness, likely due to beliefs that mental illness was associated with the presence of spirits or demons [15,16].

Such avoidance was also present in ancient Greece, as although individuals with mental illness were allowed to remain in society, they were avoided and disregarded [17]. Even during the Renaissance, despite a growth in knowledge and rationalization regarding mental illness [18], treatments remained scarce and limited, with stigma persisting. However, although the Renaissance marked the beginning of attempts to explain mental illness, this explanation was not accompanied by a medical perspective, thus maintaining the isolation and confinement of patients.

Thus, the understanding of mental illness has evolved, and also the comprehension and treatment of the patients. However, despite the recent and highly significant advancements in the understanding and treatment of mental illness, the apex may have been the stigma implemented during the Nazi era regarding mental illness, where, as Strous [19] points out, it was the first time in history that psychiatrists systematically exterminated their patients.

Lately, from the 1950s onwards, the process of deinstitutionalization began, accompanying the advancement of psychiatric treatments. Nevertheless, due to inadequate services

and the persistence of stigma surrounding mental illness, many individuals end up on the streets or in prison [20].

With the ongoing process of developing knowledge and mental healthcare, the need to integrate patients into society arose, based on the concept of psychosocial rehabilitation. It was during this phase that fighting social stigma became more imperative than ever, as it hinders the patient's integration into the community [21], and consequently, their recovery.

Regarding psychosocial rehabilitation, it is worth noting that one of its pillars is the family. It is known that familiarity and experience with mental illness appear to be inversely related to stigma. Therefore, close family members are less likely to develop stigmatizing attitudes, thus serving as a resource in seeking care [22–24]. However, some factors can discourage families from seeking mental health care, such as negative experiences with mental health professionals [25], lack of social support within the family [26], and cultural values and beliefs.

While it has been suggested that some family members may stigmatize their relatives with mental illness [27], caution should be exercised in distinguishing between family stigma and the typical tension and conflict that arises when family members receive news about the illness and how they can help [25] or even family perceptions that society stigmatizes people with mental illness, without necessarily endorsing those stereotypes themselves.

In younger individuals, it has become evident that they experience stigmatization from both adults and children [28–30]. Research has shown that this young population is more stigmatized for their mental illness than children with physical illnesses or learning difficulties [31] and that stigmatizing views and behaviors can develop since childhood. Furthermore, it should be noted that these children constitute one of the most vulnerable groups to stigma due to their inherently lower social status [32]. Additionally, around the age of six, children seem to understand common terms associated with mental illness, and by age ten, they appear to be well acquainted with cultural stereotypes, a familiarity that may occur earlier if they belong to a stigmatized group [33,34]. It is believed that in younger children, stigmatizing views develop through the assimilation of their parents'/caregivers' views [33], media representation, and cognitive development [35].

Additionally, assuming that social exclusion is associated with social stigma, the model proposed by Reinhard et al. [36] suggests an interaction between psychiatric disorders and social exclusion. It is based on an interplay between biological and environmental factors that increase the risk of developing psychiatric symptoms. These symptoms may be associated with dysfunctional social interactions, neurobiological changes, and/or increased sensitivity to rejection, which can elevate the risk of being excluded by others. Due to specific reactions to exclusion and maladaptive coping styles, psychiatric symptoms may escalate, and the disorder is perpetuated.

The understanding of this proposal is crucial since it highlights the dangerous cycle perpetuated by specific conditions, exacerbated by exclusion and stigmatization.

However, it is noteworthy that stigma also arises at the highest levels of society, at the cultural and institutional levels. Despite various measures and laws aimed at facilitating the inclusion of individuals with mental illness, concerns persist about the shortage of residential and professional responses, which may be associated with 'structural stigma'.

## Structural Stigma

Structural stigma refers to the broad societal forces, including cultural norms and institutional policies, that limit the opportunities, resources, and well-being of stigmatized populations [37,38]. The role of this macro-social form of stigma has been gaining importance because of its capacity to produce negative outcomes for members of stigmatized

groups, including individuals with mental illness [37,39]. Structural stigma often intersects with other forms of discrimination, such as racism, sexism, and ableism [40,41]. This intersectionality creates a compounding effect, where individuals from multiple marginalized groups face even greater barriers and challenges [42].

As it is embedded in systems and institutions, such as healthcare, education, and the legal system, structural stigma requires a multifaceted approach, including policy reforms, public education campaigns, and anti-discrimination initiatives [43].

In the absence of adequate family support, the institutional policies are the measures that ensure the socio-professional reintegration of the patient [44,45]. However, these measures can prejudice the person, eliciting self-stigma.

### *2.2. Self-Stigma*

Self-stigma is another dimension encompassed within the stigma of mental illness, which can be divided into three progressive stages: (1) stereotype awareness, (2) personal agreement, and (3) self-concurrence [46,47].

The level of "stereotype awareness" (1) corresponds to the extent to which the individual is aware of the social stigma they are subjected to [48,49]. Thus, the greater this awareness, the higher the likelihood of the individual internalizing the social stigma, and agreeing with the judgments of others, which can then lead to self-stigma [50]. This entire process can also lead to unfavorable behaviors in line with stereotypes (such as social withdrawal), resulting in a perpetuating negative cycle [48], which implies self-occurrence.

Overall, the consequence of this entire process is reduced self-esteem and treatment adherence, leading to poorer long-term outcomes [51–53]. As Corrigan [9] notes, stigma is the social expression of disempowerment of individuals with mental illness. Kingdon et al. [54] also frame self-stigma as self-affirmations leading to depression, anxiety, and anger, contributing to avoiding seeking help.

### *2.3. Label Avoidance*

A third type of stigma involves label avoidance, which significantly impacts the use of psychiatric services by patients. According to Corrigan et al. [55], seeking mental health services can lead to public stigma, where people are labeled by their mental health struggles. To avoid this label, individuals often refrain from using the services that could help them, or they discontinue using these services if they have already started.

Vogel et al. [56] refer to this phenomenon as self-stigma in seeking psychological help. This conceptualization contrasts with Corrigan's view, which considers it label avoidance, defining it as the act of evading stigma by refusing the status of a mental health patient and avoiding institutions and services that might lead to such a label [57]. Regardless of the terminology, the focus should be on the severe consequences of this behavior, as it reduces individuals' adherence to the care they need.

It is important to note that certain conditions, such as schizophrenia spectrum disorders, can manifest with anosognosia, hindering treatment adherence [58–61]. Anosognosia is a neurological condition characterized by a person's inability to recognize their own illness or impairment [58,62].

This notion may also be linked with stigma among healthcare professionals, directly influencing their decisions regarding the care they provide to individuals with mental illnesses [63–67]. Perceptions of treatment adherence may mediate the relationship between healthcare professional stigma and treatment decisions. As Corrigan et al. [68] suggest, those with stigmatizing attitudes may believe that individuals with mental illness have lower adherence to treatment recommendations, leading healthcare professionals to offer

fewer treatment options to individuals with severe mental illnesses. This can lead to inadequate treatment and worsened health outcomes.

### *2.4. Family and Vicarious Stigma*

Family stigma, also known as "courtesy stigma", is a term first used by Goffman [4] in 1963 that describes the discrimination and prejudice faced by family and friends due to their association with an individual with a mental illness.

Similar to individuals with mental illness, those close to them can also suffer from social stigma and, eventually, self-stigma [69–72]. According to Moses [69], it is common for friends, neighbors, and co-workers to blame the individual for their family member's mental illness or the slow or lack of recovery. Others believe that family members are "infected" by the illness or that it is contagious and thus avoid them. As expected, some family members internalize these stereotypes, leading to self-stigma.

However, family members and friends are also susceptible to another type of stigma that causes significant suffering [73]. It is the case of vicarious stigma, a construct that has been studied in the last decades. Corrigan and Miller [74] define vicarious stigma as the sadness and helplessness a family member feels when they see their loved one subjected to discrimination or prejudice due to their mental illness. For instance, Eaton et al. [75] found that parents who witness their children being stigmatized experience feelings of sadness, guilt, and anger. Furthermore, according to the study by Serchuk et al. [76], self-stigma and sadness due to vicarious stigma are significantly associated with higher levels of depression and a diminished quality of life. Considering the different types of stigma previously described, it is important to develop a new model.

## 3. Model Proposal

Based on the research in the field of stigma, this proposed model, presented schematically in Figure 1, aims to encompass the various dimensions related to individuals with mental illness and their families.

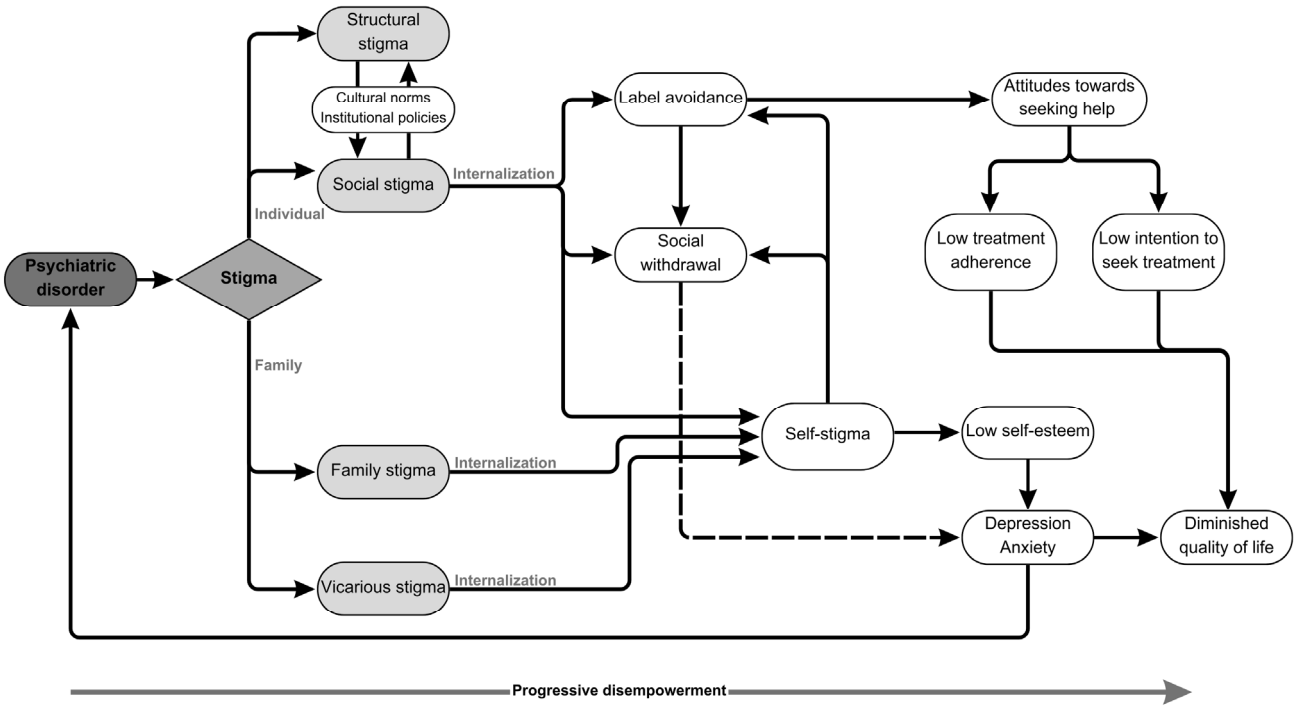


**Figure 1.** Proposal for the development of stigma in its dimensions related to the individual with mental illness and their family members.

More specifically, using the literature theories about the stigma/mental health interplay, it aims to provide an educational model for understanding stigma development and its consequences as well as facilitating the construction of future anti-stigma programs.

In the first dimension, the individual is subjected to social stigma, leading to label avoidance and/or self-stigma. Given the interplay between society, policy-making, and cultural and religious norms [37–39,43,77], it is proposed that structural stigma emerges from the interaction between these societal forces that shape social stigma and structural stigma.

In the family dimension, family stigma and vicarious stigma are presented, both of which, as we have seen, can lead to self-stigma. From our perspective, based on the development of this topic by various authors, we believe that self-stigma is the most detrimental state as it brings the most negative consequences to both individuals with mental illness and their families. Moreover, as supported by the studies of Vogel, Wade, and Hackler [56] and Pryor and Bathje [78], self-stigma predicts label avoidance in individuals with mental illness.

However, considering the interactions discussed in the study by Kosyluk et al. [79], which introduce the dimension of social withdrawal as a result of social stigma and emphasize that this also predicts the levels of label avoidance, it is also important to include components related to attitudes towards seeking help and the intention to seek treatment. Therefore, as the authors propose and this model compiles, label avoidance predicts attitudes toward seeking help, and these attitudes, in turn, seem to predict the intention to seek treatment [79]. Additionally, based on various authors [51–54], the entire process of developing self-stigma leads the individual/family to reduced self-esteem, lower treatment adherence, and self-concurrence, which result in depression and anxiety. We understand that all these factors lead to a decreased quality of life.

We can also consider that this entire process is characterized by the progressive disempowerment of the stigmatized individuals.

Additionally, it is important to highlight the complexity of the interactions between all these dimensions, which often lead to mutually reinforcing negative effects. This is evident not only in the model by Kosyluk et al. [79], but also in the model by Reinhard et al. [36] concerning the exclusion-mental disorder interaction.

Finally, regarding the proposed model, it is important to mention that the negative consequences for family members can be either objective or subjective [80,81]. Objective consequences include limitations in routine across the social, occupational, and family quality of life domains, while subjective consequences include psychological reactions such as depression and anxiety [82–84]. Given that a family member may develop a disorder or condition requiring mental health intervention, it is entirely plausible that they are also at risk and may undergo the stages related to social stigma experienced by individuals with mental illness. Therefore, in this model, it is crucial to link self-stigma as a consequence of both individual and family dimensions. In this context, family members could be directly affected by social stigma, potentially developing a mental disorder themselves.

Given all these naturally complex interactions and progressions, it remains essential to focus on combating stigma at its roots by prioritizing prevention, topics that are presented in the next section.

## 4. Further Considerations in Combating Stigma

In recent decades, various studies have been conducted in the field of stigma [85–89], in particular stigma related to mental illness, converging toward two crucial objectives: understanding and counteracting stigma. Only by combating stigma can we truly prevent the negative effects it brings for both individuals with mental illness and their family

and friends. With this in mind, several studies have been conducted to understand the best strategies to assist in addressing stigma, with the main programs developed in recent decades divided into two broad groups: contact interventions and educational interventions.

According to the National Academies of Sciences and Medicine [90], in contact-based anti-stigma interventions, individuals with lived experience of mental illness interact with the public, sharing their challenges and success stories. These strategies aim to reduce social stigma, but they have also been shown to diminish self-stigma by fostering a sense of empowerment and improving self-esteem [91,92].

Educational interventions, on the other hand, provide factual information about general or specific conditions that are often stigmatized, aiming to correct misinformation or negative attitudes and beliefs [90].

According to the study by Corrigan et al. [93], both educational and contact-based interventions appear to have positive effects on reducing stigma in adults and adolescents regarding mental illness. Specifically, contact-based intervention seems to yield superior results in reducing stigma among adults, while educational intervention appears to be more effective in adolescents, which was recently corroborated by the meta-analysis of Song et al. [94].

However, in the review by Mehta et al. [95], the authors point out that the evidence is modest regarding the effectiveness of anti-stigma interventions beyond four weeks of follow-up, specifically in terms of increasing knowledge and reducing stigmatizing attitudes. Moreover, overall, studies do not seem to support the view that contact-based intervention is more effective in improving attitudes in the medium to long term. Therefore, it is suggested that methodologically superior studies are needed to understand which anti-stigma interventions should be prioritized in the future.

Similarly, but concerning severe mental illnesses, the studies by Morgan et al. [96] and Song, Hugh-Jones, West, Pickavance, and Mir [94] showed that contact and educational interventions have a small-to-medium immediate effect on the stigma directed toward these individuals. Thus, it is suggested that further studies should be conducted to investigate how to sustain the benefits of these stigma-fighting programs over an extended period, as well as to understand the most crucial aspects of these interventions to maximize their effectiveness.

Beyond traditional methods, internet-based interventions have emerged. For example, Griffiths et al. [97] assert that these programs can be as effective in reducing stigma as in-person interventions. In another study, Goh et al. [98] concluded that online interventions can reduce stigma; therefore, mental health organizations may consider adopting such a tool as a facilitator to reach a larger number of people.

Essentially, and as concluded by the study of Simões de Almeida et al. [99], specific campaigns promoting mental health literacy should be tailored to different profiles within the population. Therefore, it is important to explore stigma in specific settings to develop targeted strategies that address the unique challenges and needs of the various groups.

For example, and as mentioned before, stigma among healthcare professionals directly impacts their decisions regarding the care they provide to individuals with mental illnesses [63–67].

Regarding programs to combat stigma in these professionals, the meta-analysis results of Lien et al. [100] indicated that both social avoidance and healthcare professionals' attitudes towards mental illness improved over time. These findings provide empirical evidence that anti-stigma programs and courses can have positive effects on these professionals, improving the quality of healthcare services provided. Moreover, the issue of stigma among students has been under growing scrutiny in recent years. A study by Eisenberg et al. [101] revealed that only 36% of university students with mental health

concerns sought support services. These authors highlight the gravity of the situation, especially considering that universities are among the few institutions that typically offer mental health services at no cost to their students.

Building on this understanding, Kosyluk et al. [79] sought to investigate the factors influencing help-seeking behaviors among university students with mental illness. Their findings confirmed that increasing familiarity with mental health can positively impact stigma and social avoidance. These results align with studies conducted on the general adult population [24,93], suggesting that direct contact and interactions with individuals with mental illness serve as an effective tool in combating stigma.

In addition, the model proposed by Kosyluk et al. [79] further suggests that label avoidance, attitudes toward seeking help, and the intention to seek treatment can also be improved through interventions that aim to increase familiarity or direct contact with individuals with mental illness. As the authors suggest, there are various ways to implement these methods in an academic setting. Examples include inviting guest speakers with lived experience of mental illness and providing learning experiences in mental health service organizations, among others.

Another study led by Kosyluk et al. [102] examined the impact of a contact-based and educational anti-stigma intervention on the university population. This randomized controlled trial also supported the notion that increasing familiarity can lead to a decrease in stigma and social avoidance, ultimately improving attitudes towards seeking help and the intention to seek help from formal support sources.

Furthermore, Yamaguchi et al. [103] conducted a systematic review of anti-stigma programs in university students, concluding that direct and video-based contact interventions were the most effective types of interventions for changing attitudes and reducing social avoidance. On the contrary, Corrigan, Morris, Michaels, Rafacz, and Rusch [93] suggested in their study that direct contact was more effective in reducing stigma than video contact. In a younger population, Meilsmeidth et al. [104] show how a b-learning school-based program can be effective in increasing mental health knowledge and decreasing stigma towards mental illnesses.

To summarize the findings from educational institutions, the review by Waqas et al. [105] aimed to understand the effectiveness of anti-stigma interventions among students in improving knowledge, attitudes, and beliefs related to mental health disorders. The results showed a significant proportion of trials with significant improvements in stigma, attitudes, help-seeking, social distancing, mental health awareness, and depression detection. Overall, it was concluded that most interventions appear to promote improvements in mental health literacy, attitudes, and beliefs towards mental illnesses, reducing not only social stigma but also self-stigma. However, specific differences between students from different courses should also be considered. Intending to understand the differences between the attitudes of future health professionals toward mental illness, Barbosa [106] conducted a study and concluded that Nursing and Occupational Therapy students showed lower values of stigmatizing attitudes compared with Medicine and Psychology students. By analyzing data from different academic stages, the author also confirmed that familiarity with mental illness is inversely correlated with stigma.

Stereotypes are typically associated with specific mental illnesses. As an example, Angermeyer and Matschinger [107] note that individuals with schizophrenia are often perceived as dangerous, while those with depression are viewed as weak.

As a result, researchers have also conducted studies to understand this phenomenon concerning particular conditions. This focused work allows for the development of tailored programs aiming to reduce the stigma associated with specific mental health conditions. Examples include Alzheimer's disease [108], schizophrenia [24,109–114], borderline person-

ality disorder [115–117], social anxiety [118], and depression [119–121], among many others. Thus, it is also important to understand how these mental health problems are comparatively perceived. For example, people with schizophrenia, alcoholism, and drug addiction can be perceived as more unpredictable and dangerous compared to severe depression, dementia, or eating disorders [122], and people with eating disorders may be more blamed for their condition in comparison to people with major depressive disorder [123].

Despite this specificity being necessary, it is equally important to continue investigating the general mechanisms of stigma in mental illness to deepen our understanding of the issue. The study by Mayer et al. [124] suggests that disclosing mental illness, especially to family members, has a positive impact on quality of life and recovery. Therefore, it is crucial to develop programs for individuals with mental illness to assist them in making informed decisions about disclosing their condition.

Focusing on the association between "difference" and disdain, Corrigan et al. [125] indicate that these are positively mediated by anger and negatively mediated by empathy. Thus, studying "difference" and disdain is essential as they appear to be significant constructs in predicting and evaluating stigma change, making them valuable dimensions in designing anti-stigma programs.

Regarding family self-stigma, Hasson-Ohayon et al. [126] suggest that understanding severe mental illness can negatively impact the parents of individuals with severe mental illness. As McFarlane [127] points out, it is crucial to develop interventions that focus on the self-stigma that may arise from increased understanding resulting from psychoeducational interventions.

In this regard, the National Alliance on Mental Illness (NAMI) offers valuable support to families dealing with a member's mental illness. Comprehensive programs designed to assist and educate families can be accessed through their website: NAMI Mental Health Education.

## 5. Conclusions

By integrating the complex multidimensional processes and concepts of stigma, this study's novel model pretends to offer a more comprehensive understanding of stigma development in mental illness. This understanding also intends to provide valuable knowledge for the development of new and targeted anti-stigma interventions. It can inform the development of targeted interventions in public health campaigns, healthcare settings, and occupational settings like workplaces and schools.

However, it is important to acknowledge the limitations of this model. Further research is needed to refine and validate its constructs and to explore its applicability across diverse cultural and societal contexts.

Finally, given the proliferation of hate speech targeting individuals based on differences such as race, nationality, religion, or sexual orientation, fostered by certain social movements, it is crucial to address stigma as a multifaceted issue. By understanding the intricate interplay between individual, interpersonal, and societal factors that contribute to stigma, we can develop effective strategies to promote inclusion and integration. Future research should focus on identifying and evaluating interventions that target both individual and systemic levels of stigma.

In conclusion, this study provides a valuable foundation for future research and intervention development.

**Author Contributions:** Conceptualization, J.M.R.; data curation, J.M.R.; methodology, J.M.R.; supervision and validation, C.Q.; visualization, J.M.R., A.S.C. and C.Q.; writing—original draft, J.M.R.; writing—review and editing, J.M.R., A.S.C. and C.Q. All authors have read and agreed to the published version of the manuscript.

**Funding:** This research received no external funding.

**Institutional Review Board Statement:** Not applicable.

**Informed Consent Statement:** Not applicable.

**Data Availability Statement:** The original contributions presented in this study are included in the article. Further inquiries can be directed to the corresponding author.

**Acknowledgments:** The authors express their sincere gratitude to the reviewers for their constructive criticism, which greatly enhanced the quality of this article.

**Conflicts of Interest:** The authors declare no conflicts of interest.

## References

1. Liamputtong, P.; Kitisriworapan, S. Deviance, difference, and stigma as social determinants of health. In *Health, Illness, and Well-being: Perspectives and Social Determinants*; Oxford University Press: Oxford, UK, 2012; pp. 242–256.
2. Manning, P. *Erving Goffman and Modern Sociology*; John Wiley & Sons: Hoboken, NJ, USA, 2013.
3. Fine, G.A.; Manning, P. Erving Goffman. In *The Blackwell Companion to Major Contemporary Social Theorists*; John Wiley & Sons: Hoboken, NJ, USA, 2003; pp. 34–62.
4. Goffman, E. *Stigma: Notes on the Management of Spoiled Identity*; Simon and Schuster: New York, NY, USA, 2009.
5. Davis, L.J. (Ed.) Erving Goffman. Selections From Stigma. In *The Disability Studies Reader*; Taylor & Francis: Abingdon, UK, 2016.
6. Link, B.G.; Phelan, J.C. Conceptualizing stigma. *Annu. Rev. Sociol.* **2001**, *27*, 363–385. [CrossRef]
7. Shah, B.B.; Nieweglowski, K.; Corrigan, P.W. Perceptions of difference and disdain on the self-stigma of mental illness. *J. Ment. Health* **2020**, *31*, 22–28. [CrossRef] [PubMed]
8. Deviance and Social Stigma. *Sociology* **2021**, 403–404.
9. Corrigan, P.W. *The Stigma of Disease and Disability: Understanding Causes and Overcoming Injustices*; American Psychological Association: Washington, DC, USA, 2014.
10. Corrigan, P.W.; O'Shaughnessy, J.R. Changing mental illness stigma as it exists in the real world. *Aust. Psychol.* **2007**, *42*, 90–97. [CrossRef]
11. Corrigan, P.W.; Wassel, A. Understanding and influencing the stigma of mental illness. *J. Psychosoc. Nurs. Ment. Health Serv.* **2008**, *46*, 42–48. [CrossRef]
12. De Toledo Piza Peluso, É.; Blay, S.L. Public beliefs about the treatment of schizophrenia and depression in Brazil. *Int. J. Soc. Psychiatry* **2009**, *55*, 16–27. [CrossRef]
13. Pescosolido, B.A.; Monahan, J.; Link, B.G.; Stueve, A.; Kikuzawa, S. The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *Am. J. Public Health* **1999**, *89*, 1339–1345. [CrossRef]
14. Corrigan, P.W. Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry* **2016**, *15*, 67–73. [CrossRef]
15. Giumbelli, E. Heresia, doença, crime ou religião: O Espiritismo no discurso de médicos e cientistas sociais. *Rev. Antropol.* **1997**, *40*, 31–82. [CrossRef]
16. Barlow, D.H.; Durand, V.M. *Abnormal Psychology: An Integrative Approach*; Cengage Learning: Boston, MA, USA, 2014.
17. Cordeiro, J.C.D. *Manual de Psiquiatria Clínica*; Fundação Calouste Gulbenkian, Serviço de Educação: Lisboa, Portugal, 1986.
18. Alves, F. *A Doença Mental nem Sempre é Doença: Racionalidades Leigas Sobre Saúde e Doença Mental*; Edições Afrontamento: Porto, Portugal, 2010.
19. Strous, R.D. Psychiatry during the Nazi era: Ethical lessons for the modern professional. *Ann. Gen. Psychiatry* **2007**, *6*, 8. [CrossRef]
20. Torrey, E.F. *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*; A Joint Report of the National Alliance for the Mentally Ill and Public Citizen's Health Research Group; Public Citizen's Health Research Group: Washington, DC, USA, 1992.
21. Villares, C.C.; Sartorius, N. Challenging the stigma of schizophrenia. *Braz. J. Psychiatry* **2003**, *25*, 1–2. [CrossRef] [PubMed]
22. Angermeyer, M.C.; Holzinger, A.; Matschinger, H. Mental health literacy and attitude towards people with mental illness: A trend analysis based on population surveys in the eastern part of Germany. *Eur. Psychiatry* **2009**, *24*, 225–232. [CrossRef] [PubMed]
23. Corrigan, P.W.; Green, A.; Lundin, R.; Kubiak, M.A.; Penn, D.L. Familiarity with and social distance from people who have serious mental illness. *Psychiatr. Serv.* **2001**, *52*, 953–958. [CrossRef] [PubMed]
24. Sousa, S.D.; Marques, A.; Rosário, C.; Queirós, C. Stigmatizing attitudes in relatives of people with schizophrenia: A study using the Attribution Questionnaire AQ-27. *Trends Psychiatry Psychother.* **2012**, *34*, 186–197. [CrossRef]
25. Lefley, H.P. Family burden and family stigma in major mental illness. *Am. Psychol.* **1989**, *44*, 556–560. [CrossRef]

26. Mitchell, M.E. The Relationship between Social Network Variables and the Utilization of Mental-Health Services. *J. Community Psychol.* **1989**, *17*, 258–266. [CrossRef]
27. Moses, T. Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Soc. Sci. Med.* **2010**, *70*, 985–993. [CrossRef]
28. Weiss, M.F. Children's attitudes toward the mentally ill: A developmental analysis. *Psychol. Rep.* **1986**, *58*, 11–20. [CrossRef]
29. Adler, A.K.; Wahl, O.F. Children's beliefs about people labeled mentally ill. *Am. J. Orthopsychiatry* **1998**, *68*, 321–326. [CrossRef]
30. Rose, D.; Thornicroft, G.; Pinfold, V.; Kassam, A. 250 labels used to stigmatise people with mental illness. *BMC Health Serv. Res.* **2007**, *7*, 97. [CrossRef]
31. Wilkins, J.E.; Velicher, W.F. A semantic differential investigation of children's attitudes toward three stigmatized groups. *Psychol. Sch.* **1980**, *17*, 364–371. [CrossRef]
32. Phares, V. *Understanding Abnormal Child Psychology*; John Wiley & Sons: Hoboken, NJ, USA, 2020.
33. Gale, F. Tackling the stigma of mental health in vulnerable children and young people. In *Mental Health Interventions and Services for Vulnerable Children and Young People*; Jessica Kingsley Publishers: London, UK, 2007; pp. 58–80.
34. Costello, E.J.; Foley, D.L.; Angold, A. 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: II. Developmental epidemiology. *J. Am. Acad. Child Adolesc. Psychiatry* **2006**, *45*, 8–25. [CrossRef] [PubMed]
35. Donenberg, G.R.; Pao, M. Youths and HIV/AIDS: Psychiatry's role in a changing epidemic. *J. Am. Acad. Child Adolesc. Psychiatry* **2005**, *44*, 728–747. [CrossRef] [PubMed]
36. Reinhard, M.A.; Dewald-Kaufmann, J.; Wustenberg, T.; Musil, R.; Barton, B.B.; Jobst, A.; Padberg, F. The vicious circle of social exclusion and psychopathology: A systematic review of experimental ostracism research in psychiatric disorders. *Eur. Arch. Psychiatry Clin. Neurosci.* **2020**, *270*, 521–532. [CrossRef]
37. Hatzenbuehler, M.L.; Link, B.G. Introduction to the special issue on structural stigma and health. *Soc. Sci. Med.* **2014**, *103*, 1–6. [CrossRef]
38. Hatzenbuehler, M.L. Structural stigma: Research evidence and implications for psychological science. *Am. Psychol.* **2016**, *71*, 742–751. [CrossRef]
39. Evans-Lacko, S.; Brohan, E.; Mojtabai, R.; Thornicroft, G. Association between public views of mental illness and self-stigma among individuals with mental illness in 14 European countries. *Psychol. Med.* **2012**, *42*, 1741–1752. [CrossRef]
40. Williams, D.R.; Williams-Morris, R. Racism and mental health: The African American experience. *Ethn. Health* **2000**, *5*, 243–268. [CrossRef]
41. Berry, J.W. Research on multiculturalism in Canada. *Int. J. Intercult. Relat.* **2013**, *37*, 663–675. [CrossRef]
42. Jackson, J.W.; Williams, D.R.; VanderWeele, T.J. Disparities at the intersection of marginalized groups. *Soc. Psychiatry Psychiatr. Epidemiol.* **2016**, *51*, 1349–1359. [CrossRef]
43. Sukhera, J.; Knaak, S.; Ungar, T.; Rehman, M. Dismantling Structural Stigma Related to Mental Health and Substance Use: An Educational Framework. *Acad Med.* **2022**, *97*, 175–181. [CrossRef] [PubMed]
44. Nogueira, M.L.-S.P. *Inclusão Social e Bem-Estar da Pessoa Doente Mental: Contributos de um estudo de caso num serviço de psiquiatria*; Universidade do Porto: Porto, Portugal, 2013.
45. Lasky-Fink, J.; Linos, E. Improving Delivery of the Social Safety Net: The Role of Stigma. *J. Public Adm. Res. Theory* **2024**, *34*, 270–283. [CrossRef]
46. Corrigan, P. *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change*; American Psychological Association: Washington, DC, USA, 2005.
47. Corrigan, P.W.; Watson, A.C.; Barr, L. The self–stigma of mental illness: Implications for self–esteem and self–efficacy. *J. Soc. Clin. Psychol.* **2006**, *25*, 875–884. [CrossRef]
48. Pinel, E.C. Stigma consciousness: The psychological legacy of social stereotypes. *J. Pers. Soc. Psychol.* **1999**, *76*, 114–128. [CrossRef]
49. Thornicroft, G.; Rose, D.; Kassam, A.; Sartorius, N. Stigma: Ignorance, prejudice or discrimination? *Br. J. Psychiatry* **2007**, *190*, 192–193. [CrossRef]
50. Corrigan, P.W.; Watson, A.C. Understanding the impact of stigma on people with mental illness. *World Psychiatry* **2002**, *1*, 16–20.
51. Corrigan, P.W.; Watson, A.C. The paradox of self-stigma and mental illness. *Clin. Psychol.-Sci. Pract.* **2002**, *9*, 35–53. [CrossRef]
52. Fung, K.M.T.; Tsang, H.W.H.; Corrigan, P.W. Self-stigma of people with schizophrenia as predictor of their adherence to psychosocial treatment. *Psychiatr. Rehabil. J.* **2008**, *32*, 95–104. [CrossRef]
53. Clement, S.; Schauman, O.; Graham, T.; Maggioni, F.; Evans-Lacko, S.; Bezborodovs, N.; Morgan, C.; Rüsch, N.; Brown, J.S.; Thornicroft, G. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychol. Med.* **2015**, *45*, 11–27. [CrossRef]
54. Kingdon, D.; Turkington, D.; John, C. Cognitive behaviour therapy of schizophrenia. The amenability of delusions and hallucinations to reasoning. *Br. J. Psychiatry* **1994**, *164*, 581–587. [CrossRef]
55. Corrigan, P.W.; Bink, A.B.; Schmidt, A.; Jones, N.; Rüsch, N. What is the impact of self-stigma? Loss of self-respect and the "why try" effect. *J. Ment. Health* **2016**, *25*, 10–15. [CrossRef] [PubMed]

56. Vogel, D.L.; Wade, N.G.; Hackler, A.H. Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *J. Couns. Psychol.* **2007**, *54*, 40–50. [CrossRef]
57. Corrigan, P. How stigma interferes with mental health care. *Am. Psychol.* **2004**, *59*, 614–625. [CrossRef]
58. Vuilleumier, P. Anosognosia: The Neurology of Beliefs and Uncertainties. *Cortex* **2004**, *40*, 9–17. [CrossRef]
59. Torrey, E.F.; Lieberman, J. The Underuse of Clozapine and Long-Acting Injectable Antipsychotics. *Psychiatr. Serv.* **2024**, *76*, 90–92. [CrossRef] [PubMed]
60. Cummings, M.A.; Arias, A.-L.W.; Stahl, S.M. What is the neurobiology of schizophrenia? *CNS Spectr.* **2024**, 1–6. [CrossRef] [PubMed]
61. Castrillo Sanz, A.; Andrés Calvo, M.; Repiso Gento, I.; Izquierdo Delgado, E.; Gutierrez Ríos, R.; Rodríguez Herrero, R.; Rodríguez Sanz, F.; Tola-Arribas, M.A. Anosognosia in Alzheimer disease: Prevalence, associated factors, and influence on disease progression. *Neurol. Engl. Ed.* **2016**, *31*, 296–304. [CrossRef]
62. Cutting, J. Study of anosognosia. *J. Neurol. Neurosurg. Amp;Amp; Psychiatry* **1978**, *41*, 548. [CrossRef]
63. Thornicroft, G.; Rose, D.; Kassam, A. Discrimination in health care against people with mental illness. *Int. Rev. Psychiatry* **2007**, *19*, 113–122. [CrossRef]
64. Jones, S.; Howard, L.; Thornicroft, G. 'Diagnostic overshadowing': Worse physical health care for people with mental illness. *Acta Psychiatr. Scand.* **2008**, *118*, 169–171. [CrossRef]
65. Sheehan, L.; Corrigan, P. Stigma of Disease and Its Impact on Health. In *The Wiley Encyclopedia of Health Psychology*; Wiley: Hoboken, NJ, USA, 2020; pp. 57–65.
66. Pinto, I.C.; Bernardo, M.; Sousa, S.; Curral, R. Evaluation of mental health stigma on medical education: An observational study with Portuguese medical students. *Porto Biomed. J.* **2020**, *5*, e074. [CrossRef] [PubMed]
67. Marques, A.J.; Barbosa, T.; Queiros, C. P03-270—Stigma in mental health: Perceptions of students who will be future health professionals. *Eur. Psychiatry* **2011**, *26*, 1439. [CrossRef]
68. Corrigan, P.W.; Mittal, D.; Reaves, C.M.; Haynes, T.F.; Han, X.; Morris, S.; Sullivan, G. Mental health stigma and primary health care decisions. *Psychiatry Res* **2014**, *218*, 35–38. [CrossRef] [PubMed]
69. Moses, T. Stigma and family. In *The Stigma of Disease and Disability: Understanding Causes and Overcoming Injustices*; Corrigan, P.W., Ed.; American Psychological Association: Washington, DC, USA, 2014; pp. 247–268.
70. Phelan, J.C.; Bromet, E.J.; Link, B.G. Psychiatric illness and family stigma. *Schizophr. Bull.* **1998**, *24*, 115–126. [CrossRef] [PubMed]
71. Struening, E.L.; Perlick, D.A.; Link, B.G.; Hellman, F.; Herman, D.; Sirey, J.A. Stigma as a barrier to recovery: The extent to which caregivers believe most people devalue consumers and their families. *Psychiatr. Serv.* **2001**, *52*, 1633–1638. [CrossRef]
72. van der Sanden, R.L.; Bos, A.E.; Stutterheim, S.E.; Pryor, J.B.; Kok, G. Experiences of stigma by association among family members of people with mental illness. *Rehabil. Psychol.* **2013**, *58*, 73. [CrossRef]
73. Robinson, M.A.; Brewster, M.E. Understanding affiliate stigma faced by heterosexual family and friends of LGB people: A measurement development study. *J. Fam. Psychol.* **2016**, *30*, 353–363. [CrossRef]
74. Corrigan, P.W.; Miller, F.E. Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *J. Ment. Health* **2004**, *13*, 537–548. [CrossRef]
75. Eaton, K.; Ohan, J.L.; Stritzke, W.G.K.; Corrigan, P.W. Failing to Meet the Good Parent Ideal: Self-Stigma in Parents of Children with Mental Health Disorders. *J. Child Fam. Stud.* **2016**, *25*, 3109–3123. [CrossRef]
76. Serchuk, M.D.; Corrigan, P.W.; Reed, S.; Ohan, J.L. Vicarious Stigma and Self-Stigma Experienced by Parents of Children with Mental Health and/or Neurodevelopmental Disorders. *Community Ment. Health J.* **2021**, *57*, 1537–1546. [CrossRef]
77. Moreno, A.N.; Bartkowski, J.P.; Xu, X. Religion and Help-Seeking: Theological Conservatism and Preferences for Mental Health Assistance. *Religions* **2022**, *13*, 415. [CrossRef]
78. Pryor, J.; Bathje, G. The Relationships of Public and Self-Stigma to Seeking Mental Health Services. *J. Ment. Health Couns.* **2011**, *33*, 161–176. [CrossRef]
79. Kosyluk, K.A.; Conner, K.O.; Al-Khouja, M.; Bink, A.; Buchholz, B.; Ellefson, S.; Fokuo, K.; Goldberg, D.; Kraus, D.; Leon, A.; et al. Factors predicting help seeking for mental illness among college students. *J. Ment. Health* **2021**, *30*, 300–307. [CrossRef] [PubMed]
80. Coyne, J.C.; Kessler, R.C.; Tal, M.; Turnbull, J.; Wortman, C.B.; Greden, J.F. Living with a depressed person. *J. Consult. Clin. Psychol.* **1987**, *55*, 347–352. [CrossRef]
81. Awad, A.G.; Voruganti, L.N. The burden of schizophrenia on caregivers: A review. *Pharmacoeconomics* **2008**, *26*, 149–162. [CrossRef]
82. Cuijpers, P. The effects of family interventions on relatives' burden: A meta-analysis. *J. Ment. Health* **1999**, *8*, 275–285.
83. Magliano, L.; Fadden, G.; Madianos, M.; de Almeida, J.M.; Held, T.; Guarneri, M.; Marasco, C.; Tosini, P.; Maj, M. Burden on the families of patients with schizophrenia: Results of the BIOMED I study. *Soc. Psychiatry Psychiatr. Epidemiol.* **1998**, *33*, 405–412. [CrossRef]
84. Webb, C.; Pfeiffer, M.; Mueser, K.T.; Gladis, M.; Mensch, E.; DeGirolamo, J.; Levinson, D.F. Burden and well-being of caregivers for the severely mentally ill: The role of coping style and social support. *Schizophr. Res.* **1998**, *34*, 169–180. [CrossRef]

85. Aranda, A.M.; Helms, W.S.; Patterson, K.D.W.; Roulet, T.J.; Hudson, B.A. Standing on the Shoulders of Goffman: Advancing a Relational Research Agenda on Stigma. *Bus. Soc.* **2023**, *62*, 1339–1377. [CrossRef]
86. Ablon, J. The nature of stigma and medical conditions. *Epilepsy Behav.* **2002**, *3*, 2–9. [CrossRef]
87. Barreto, M.; van Breen, J.; Victor, C.; Hammond, C.; Eccles, A.; Richins, M.T.; Qualter, P. Exploring the nature and variation of the stigma associated with loneliness. *J. Soc. Pers. Relatsh.* **2022**, *39*, 2658–2679. [CrossRef]
88. Kurzban, R.; Leary, M.R. Evolutionary origins of stigmatization: The functions of social exclusion. *Psychol. Bull.* **2001**, *127*, 187–208. [CrossRef] [PubMed]
89. Smart Richman, L.; Leary, M.R. Reactions to discrimination, stigmatization, ostracism, and other forms of interpersonal rejection: A multimotive model. *Psychol. Rev.* **2009**, *116*, 365–383. [CrossRef] [PubMed]
90. National Academies of Sciences, Division of Behavioral, Social Sciences, Board on Behavioral, Sensory Sciences and Committee on the Science of Changing Behavioral Health Social Norms. *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change*; National Academies Press: Washington, DC, USA, 2016.
91. Corrigan, P.W.; Kosyluk, K.A.; Rusch, N. Reducing self-stigma by coming out proud. *Am. J. Public Health* **2013**, *103*, 794–800. [CrossRef] [PubMed]
92. Mendes, A.; Sousa, S. Influence of the "Porta Aberta à Saúde Mental" program in reducing the self-stigma in the three elements of the team with experience of mental illness. In Proceedings of the II Congresso Internacional da Saúde Gaia Porto, Porto, Portugal, 19–21 November 2015; p. 178.
93. Corrigan, P.W.; Morris, S.B.; Michaels, P.J.; Rafacz, J.D.; Rusch, N. Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatr. Serv.* **2012**, *63*, 963–973. [CrossRef]
94. Song, N.; Hugh-Jones, S.; West, R.M.; Pickavance, J.; Mir, G. The effectiveness of anti-stigma interventions for reducing mental health stigma in young people: A systematic review and meta-analysis. *Camb. Prism. Glob. Ment. Health* **2023**, *10*, e39. [CrossRef]
95. Mehta, N.; Clement, S.; Marcus, E.; Stona, A.C.; Bezborodovs, N.; Evans-Lacko, S.; Palacios, J.; Docherty, M.; Barley, E.; Rose, D.; et al. Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: Systematic review. *Br. J. Psychiatry* **2015**, *207*, 377–384. [CrossRef]
96. Morgan, A.J.; Reavley, N.J.; Ross, A.; Too, L.S.; Jorm, A.F. Interventions to reduce stigma towards people with severe mental illness: Systematic review and meta-analysis. *J. Psychiatr. Res.* **2018**, *103*, 120–133. [CrossRef]
97. Griffiths, K.M.; Carron-Arthur, B.; Parsons, A.; Reid, R. Effectiveness of programs for reducing the stigma associated with mental disorders. A meta-analysis of randomized controlled trials. *World Psychiatry* **2014**, *13*, 161–175. [CrossRef]
98. Goh, Y.S.; Ow Yong, Q.Y.J.; Tam, W.W. Effects of online stigma-reduction programme for people experiencing mental health conditions: A systematic review and meta-analysis. *Int. J. Ment. Health Nurs.* **2021**, *30*, 1040–1056. [CrossRef]
99. Simões de Almeida, R.; Trigueiro, M.J.; Portugal, P.; de Sousa, S.; Simões-Silva, V.; Campos, F.; Silva, M.; Marques, A. Mental Health Literacy and Stigma in a Municipality in the North of Portugal: A Cross-Sectional Study. *Int. J. Environ. Res. Public Health* **2023**, *20*, 3318. [CrossRef] [PubMed]
100. Lien, Y.Y.; Lin, H.S.; Tsai, C.H.; Lien, Y.J.; Wu, T.T. Changes in Attitudes toward Mental Illness in Healthcare Professionals and Students. *Int. J. Environ. Res. Public Health* **2019**, *16*, 4655. [CrossRef] [PubMed]
101. Eisenberg, D.; Hunt, J.; Speer, N.; Zivin, K. Mental Health Service Utilization Among College Students in the United States. *J. Nerv. Ment. Dis.* **2011**, *199*, 301–308. [CrossRef] [PubMed]
102. Kosyluk, K.A.; Al-Khouja, M.; Bink, A.; Buchholz, B.; Ellefson, S.; Fokuo, K.; Goldberg, D.; Kraus, D.; Leon, A.; Michaels, P.; et al. Challenging the Stigma of Mental Illness Among College Students. *J. Adolesc. Health* **2016**, *59*, 325–331. [CrossRef]
103. Yamaguchi, S.; Wu, S.-I.; Biswas, M.; Yate, M.; Aoki, Y.; Barley, E.A.; Thornicroft, G. Effects of Short-Term Interventions to Reduce Mental Health–Related Stigma in University or College Students: A Systematic Review. *J. Nerv. Ment. Dis.* **2013**, *201*, 490–503. [CrossRef]
104. Meilsmeidth, G.; Trigueiro, M.J.; Simões-Silva, V.; Simões de Almeida, R.; Portugal, P.; Gomes, P.V.; de Sousa, S.; Campos, F.; Monteiro, P.; Soutelo, A.P.; et al. Assessing the efficacy of the 'Bicho De 7 Cabeças' B-learning school-based program in enhancing mental health literacy and reducing stigma. *BMC Psychol.* **2024**, *12*, 93. [CrossRef]
105. Waqas, A.; Malik, S.; Fida, A.; Abbas, N.; Mian, N.; Miryala, S.; Amray, A.N.; Shah, Z.; Naveed, S. Interventions to Reduce Stigma Related to Mental Illnesses in Educational Institutes: A Systematic Review. *Psychiatr. Q.* **2020**, *91*, 887–903. [CrossRef]
106. Barbosa, T. *Estigma face à Doença Mental por parte de Futuros Profissionais de Saúde Mental*; University of Porto, Faculty of Psychology and Educational Sciences: Porto, Portugal, 2010.
107. Angermeyer, M.C.; Matschinger, H. Public beliefs about schizophrenia and depression: Similarities and differences. *Soc. Psychiatry Psychiatr. Epidemiol.* **2003**, *38*, 526–534. [CrossRef]
108. Baumgartner, S.E.; Corrigan, P.W.; Wan, H.T.; Werner, P.; Himes, C.L.; Qin, S. The difference in stigmatizing attributions toward older adults with or without Alzheimer's disease. *Stigma Health* **2023**, *8*, 467–475. [CrossRef]
109. Joseph, A.J.; Tandon, N.; Yang, L.H.; Duckworth, K.; Torous, J.; Seidman, L.J.; Keshavan, M.S. Schizophrenia: Use and misuse on Twitter. *Schizophr. Res.* **2015**, *165*, 111–115. [CrossRef]

110. Valery, K.M.; Prouteau, A. Schizophrenia stigma in mental health professionals and associated factors: A systematic review. *Psychiatry Res* **2020**, *290*, 113068. [CrossRef] [PubMed]
111. Cleary, M.; West, S.; Hunt, G.E.; McLean, L.; Kornhaber, R. A Qualitative Systematic Review of Caregivers' Experiences of Caring for Family Diagnosed with Schizophrenia. *Issues Ment. Health Nurs.* **2020**, *41*, 667–683. [CrossRef] [PubMed]
112. Koike, S.; Yamaguchi, S.; Ohta, K.; Ojio, Y.; Watanabe, K.I.; Ando, S. Mental-health-related stigma among Japanese children and their parents and impact of renaming of schizophrenia. *Psychiatry Clin. Neurosci.* **2017**, *71*, 170–179. [CrossRef] [PubMed]
113. Sousa, S.D.; Marques, A.J.; Queirós, C. P-1194—How to reduce self-stigma in schizophrenia?—An intervention through socio-drama and e-learning. *Eur. Psychiatry* **2012**, *27*, 1. [CrossRef]
114. Queiros, C.; Sousa, S.; Marques, A.J. A B-Learning course to reduced self-stigma in schizophrenia: Preparing individuals to active life. *Eur. Psychiatry* **2011**, *26*, 1485. [CrossRef]
115. Ernst, M.; Mohr, H.M.; Schott, M.; Rickmeyer, C.; Fischmann, T.; Leuzinger-Bohleber, M.; Weiss, H.; Grabhorn, R. The effects of social exclusion on response inhibition in borderline personality disorder and major depression. *Psychiatry Res.* **2018**, *262*, 333–339. [CrossRef]
116. Brown, R.C.; Plener, P.L.; Groen, G.; Neff, D.; Bonenberger, M.; Abler, B. Differential Neural Processing of Social Exclusion and Inclusion in Adolescents with Non-Suicidal Self-Injury and Young Adults with Borderline Personality Disorder. *Front. Psychiatry* **2017**, *8*, 267. [CrossRef]
117. Olie, E.; Doell, K.C.; Corradi-Dell'Acqua, C.; Courtet, P.; Perroud, N.; Schwartz, S. Physical pain recruits the nucleus accumbens during social distress in borderline personality disorder. *Soc. Cogn. Affect. Neurosci.* **2018**, *13*, 1071–1080. [CrossRef]
118. Gutz, L.; Roepke, S.; Renneberg, B. Cognitive and affective processing of social exclusion in borderline personality disorder and social anxiety disorder. *Behav. Res. Ther.* **2016**, *87*, 70–75. [CrossRef]
119. Jankowski, K.F.; Batres, J.; Scott, H.; Smyda, G.; Pfeifer, J.H.; Quevedo, K. Feeling left out: Depressed adolescents may atypically recruit emotional salience and regulation networks during social exclusion. *Soc. Cogn. Affect. Neurosci.* **2018**, *13*, 863–876. [CrossRef]
120. Jobst, A.; Sabass, L.; Palagyi, A.; Bauriedl-Schmidt, C.; Mauer, M.C.; Sarubin, N.; Buchheim, A.; Renneberg, B.; Falkai, P.; Zill, P.; et al. Effects of social exclusion on emotions and oxytocin and cortisol levels in patients with chronic depression. *J. Psychiatr. Res.* **2015**, *60*, 170–177. [CrossRef] [PubMed]
121. Prizeman, K.; Weinstein, N.; McCabe, C. Effects of mental health stigma on loneliness, social isolation, and relationships in young people with depression symptoms. *BMC Psychiatry* **2023**, *23*, 527. [CrossRef] [PubMed]
122. Crisp, A.H.; Gelder, M.G.; Rix, S.; Meltzer, H.I.; Rowlands, O.J. Stigmatisation of people with mental illnesses. *Br. J. Psychiatry* **2000**, *177*, 4–7. [CrossRef] [PubMed]
123. Ebneter, D.S.; Latner, J.D. Stigmatizing Attitudes Differ Across Mental Health Disorders: A Comparison of Stigma Across Eating Disorders, Obesity, and Major Depressive Disorder. *J. Nerv. Ment. Dis.* **2013**, *201*, 281–285. [CrossRef]
124. Mayer, L.; Corrigan, P.W.; Eisheuer, D.; Oexle, N.; Rusch, N. Attitudes towards disclosing a mental illness: Impact on quality of life and recovery. *Soc. Psychiatry Psychiatr. Epidemiol.* **2021**, *57*, 363–374. [CrossRef]
125. Corrigan, P.W.; Talluri, S.S.; Qin, S. Difference and Disdain as Indicators of the Public Stigma of Mental Illness. *J. Nerv. Ment. Dis.* **2021**, *209*, 645–649. [CrossRef]

126. Hasson-Ohayon, I.; Levy, I.; Kravetz, S.; Vollanski-Narkis, A.; Roe, D. Insight into mental illness, self-stigma, and the family burden of parents of persons with a severe mental illness. *Compr. Psychiatry* **2011**, *52*, 75–80. [CrossRef]
127. McFarlane, W.R. *Multifamily Groups in the Treatment of Severe Psychiatric Disorders*; Guilford Press: New York, NY, USA, 2004.