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Research Article

Factors Influencing Adolescents Stigmatising Attitudes and Perception of Community Reaction towards Mental Illness in Nigeria

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Abstract

Background: Stigma is one of the major distresses that are experienced by people with mental illness. Stigmatisation results in a reduction in quality of life of those affected. **Objective:** The objective of this study was to assess the stigmatising attitudes of adolescents towards individuals with mental illness, their perception of community reaction and factors influencing it in Nigeria. **Method**: In school Adolescents (N = 402) participated in the research. They completed self-administered questionnaires regarding socio-demographic details and questions based on a vignette of a young person with a mental disorder using the Standardized Stigmatisation Questionnaire (SSQ1). The study was cross-sectional in nature and employed a multistage sampling technique. **Result**: The mean age was 14.44years (SD=1.84).There were 265 (65.9%) males and 137(34.1%) females. Approximately seventy percent of the adolescents would not be happy to sit next to a man with mental illness in a bus, 58.2% would not want him to teach their children, and an even higher percentage (72.9%) believe that most people in the community would do same. Seventy percent are aware that he did not develop his problems to avoid difficult situations of life and 78.2% also know that it's not a punishment for bad deeds. Independent predictors of stigma related attitude include age $p<0.002$, gender $p<0.010$ and community perception $p<0.001$. **Conclusion**: Stigmatisation of mental illness is highly prevalent among adolescents. Given that a significant percentage of the participants were well informed, formation of stigmatising attitude towards mental illness might be deeper than lack of knowledge. There may be a need to work on societal structure despite traditional education interventions and also encourage their contact with mentally ill persons.

Keywords: Stigmatisation Adolescents, community, Mental Illness, Perception, Societal structure

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1. Introduction

Stigma is one of the most intense distresses that are suffered by people with mental illness. They struggle with the symptoms and disabilities of the disease on one hand; on the other, they confront the consequences of stereotypes, prejudice and misconceptions often associated with mental illness. Stigmatisation results in people with mental illness being deprived of the opportunities for good jobs, access to satisfactory health care service, normal everyday relationships with diverse people in society and a reduction in quality of life. Stigma and associated discrimination expressed towards people with mental illness emanates from societal structures in the community and individuals' knowledge, attitudes, and behaviors [1]. Societal structures produce social knowledge within groups which are often learned [2–4]. And it represents collectively agreed notions within groups of persons [5]. Adolescents also learn this social knowledge and as individuals within these societal structures they can generate impressions and reaction of the community towards people with mental illness aside their own beliefs and attitudes. Behavior does not always agree with stated attitudes and when differences between clusters (by any label) in a society increases or is very marked, it promotes a pulling together within the clusters and a tendency to band against those perceived as different in order to preserve self-interest [6]. Previous research has established that stigmatising attitudes develop early in childhood, persists with increasing age or grade and did not change appreciably at least eight years later [7]. Attention has recently focused on the developmental expression of mental illness stigma and the subsequent design of age-appropriate stigma reduction strategies. A literature review on child and adolescent mental illness stigma reported that young children may hold negative attitudes toward individuals with mental illness and these attitudes might intensify as these children develop [8]. Strategies to combat stigma and lessen discrimination associated with mental illness are necessary so as to reduce the social injustice done to those suffering from mental illness [1, 9–12]. Strategies that have been designed to diminish stigma are educational, contact, and/or protest methods [12]. Educational methods offset stigmatising beliefs regarding mental illness by providing accurate knowledge. Contact methods offset stigmatising knowledge and attitudes via opportunities for interaction with persons with mental illness. Protest methods offset stigmatizing attitudes and behaviours by suppressing their expression. Exposure to people with mental disorders is known to reduce stigma in adults [13, 14] however, one study found that exposure increased stigma in adolescents [9]. Among these several interventions aimed at reducing stigma educational intervention appears

to have a small effect in young people [15, 16]. The societal structure holds the possibility of representation for stigmatizing attitudes, however, the influence of societal structure on adolescents stigmatizing attitudes has received only limited research in this environment. Previous studies in the country have shown that negative views and attitudes towards mental illness are widespread in the communities [17] but no study has really looked at the influence of this view and structure on the adolescents. Ongoing investigation regarding adolescent expression of stigma-related attitudes and behaviors is needed for various reasons: the extrapolation of knowledge about adult-related stigma to adolescent-related stigma is inappropriate, design of age-appropriate stigma reduction programs to minimize transition of negative attitudes from adolescence into adulthood [9–11] is much needed and the organization of programmes targeted at the societal structure in order to have long lasting reduction in stigmatisation of mental illness is desired. Even though up to 10% of children experience mental health problems, they still tend to have or hold negative attitude towards mental illness. Potential for stigmatisation of mental illness by adolescents certainly exists in non-Western cultures of Sub-Sahara Africa and have been less frequently explored. The objective of this study was to assess the stigmatising attitudes of adolescent towards individuals with mental illness, their perception of community reaction and factors influencing it in Nigeria.

2. Materials and Method

Study population:

The study was conducted in south-western Nigeria comprising majorly of Yoruba speaking populace. The region has six state among which is Osun state where the study was conducted. Participants in the study were in-school adolescents in secondary school, both male and female students, aged between 10-19 years. They were recruited from four secondary schools located in the State. The schools were selected using a multistage sampling technique and the design was cross-sectional in nature. Four hundred and ten secondary school students participated in the study and spread across the six arms of classes in each school. Two of the schools were privately owned and the other two were public schools.

1. Testing procedure

The participants gave responses to questions related to socio-demographic details such as age, sex, class, type of school, religion and ethnicity. In addition to this information participants completed an attached standardized stigmatisation questionnaire based on a vignette of a young person with a mental disorder using the Standardized Stigmatization Questionnaire (SSQ1) developed by Haghigat [6]. The vignette was written to satisfy DSM-IV criteria, an effort was also made not to give a diagnostic label but just a description of the man's behavior to elicit their ability to recognize the disorder in the vignette. The vignette was:

A man is twenty five years old. He is not married and lives with his parents. He has begun locking himself up in his room and also refuses to eat with the family. In the last 4 months he has stopped seeing his friends and His parents also hear him walking about in his bedroom at night while they are in bed. Even though they know he is alone, they hear him shouting and sometimes arguing with himself as if someone else is there. He also refuses leaving home because he feels he is being spied upon by the neighbors. Lately the doctor said he is ill.

Now what do you think most people would actually do or feel about this person if they knew his history. What will you also do or feel about this person if you knew the history.

Respondents were given questions to assess personal and perceived stigma. The first set of questions asked how they thought most people will react to the man described in the vignette in other to assess participants' perception of community reaction while the second sets of questions assess the predisposition of respondents to enact stigmatization towards the man described in the vignette. All the interviews were completed in English. Participants were instructed clearly that their names are not required and that there is no right or wrong answers. The SSQ was designed to measure subjective perception of stigma. The questionnaire has been used in relatively large surveys in Europe and across cultures and has contributed to valid and reliable assessment of stigmatization. The validity of the questionnaire items has also been reported. The questionnaire was pre-tested by 2 trained psychiatrists to establish its adaptability in our environment and a few descriptive words were replaced with common words meaning the same thing in our environment. The questionnaire has 13 items and is in two parts, Part 1 for the assessment of perceived stigmatization and Part 2 for the assessment of predisposition to enact stigma (personal stigma). The questionnaire is divided into three major domains or factors which constitute the components of stigmatization. Four items in the questionnaire assess social self-interest which is a

reflection of social distance, avoiding association with outcast or the way the society or community expects the individual in it to act. These are:

Would most people be happy to sit next to this man in a bus? Would most people be happy to eat food which he has cooked? Would most people avoid talking to him if possible? Would most people think he should stay in hospital for his whole life?

Another 4 items dealt with evolutionary self-interest which may be genetic, economic and territorial indicating the manner in which an individual is likely to react. These are:

Would most people be happy if this person became the teacher of their child? Would most people be happy if he married their sister? Would most people be happy if he were to work together with them in their work place? Would most people be frightened if this man came to live next door to them?

Five other items assess psychological self-interest, which perceives others as bad thus downplaying on one's own negative attributes. These are:

Do most people think one of the main causes of his condition is a lack of moral strength or will power? Do most people think his condition is a punishment for bad deeds? Do most people think he has developed his condition to avoid the difficult problem of everyday life? Do most people think he has become a failure in life? Would most people think this man is a bad person?

Each question has an assigned Score on a 4-point Likert scale (having the responses definitely yes, perhaps yes, perhaps no and definitely no) with alternate response categories depending on the wording of the question so that higher scores indicate stigma. A score of 1 is for least stigma attitude and a score of 4 for highest stigma attitude. The perceived stigma question also use the same set of items but with responses based on what participants thought others would do in order to elicit participants' perception of stigmatization by the community. The questions were of the type asking that "What would most people do" for perceived stigma and "What will you do" for personal stigma and so on. Data was collected over a period of one month.

1. Scale assessment and Data analysis

The Statistical package for the Social Sciences version 16.0 (SPSS Inc., Chicago) program was used for statistical analysis. Although the SSQ questionnaire has been widely used in Europe, to the best of our knowledge no evaluation has ever been undertaken to confirm its validity and reliability in our environment. For this reason the original 13 items of the instrument were assessed using an exploratory factor analysis employing

principal component analysis with varimax rotation on items on personal stigma. All assumptions of the instrument as having three main factors were maintained, namely social, evolutionary and psychological self-interest. The questionnaire was used as a summated scale with total scores ranging from a low of 13 to a high of 52, and also as subscales; higher scores equate to greater stigma. Each of the items were scored and summed resulting in stigma scales which were based on the three substructure of stigmatization and used as the dependent variables in regression analyses in trying to establish the predictors of stigma. The regression analysis examined the following as predictors of stigma; socio-demographic characteristic (age, gender, ethnicity, religion, type of school, class) and community perception (enacted). Results were calculated as frequencies (%), means and standard deviations. Significant variables were entered into a multiple logistic regression analysis to determine the predictors of stigma. All tests were two-tailed and significance was put at p-value less than 0.05. Odds ratio (OR) and 95% confidence interval was calculated for independent predictors.

3. Ethical Considerations

Ethical clearance was obtained through permission from schools review Board. All participants gave assent and a general informed consent was provided by Parent Teachers Association (PTA) of each of the participating school. The purpose of the study was explained to the students but consent was sought and obtained individually. They were also assured of confidentiality.

4. Results

1. Socio-demographic profiles of respondents

Of the 410 respondents, 8 had incomplete data; hence four hundred and two participants were analyzed. The mean age of participants in years was 14.44 (SD=1.84; range = 10-19years). There were 265 (65.9%) males and 137 (34.1%) females and their age distribution is as shown in Table1. All the three groups of adolescents as classified by international standard were in the study with 28.8% being early adolescents (10-13 years), 60.7% middle adolescents (14-16 years) and 10.5% late adolescents (17-19 years), and the participants were mostly (95.5%) from the Yoruba ethnic group which can be explained by the study location.

1. Descriptive analysis of respondent stigma attitude

Variables	Frequency (%)	Variables	Frequency (%)
Age group 10-13 years 14-16 years 17-19 years	113(28.8%) 238(60.7%) 41(10.5%)	**Ethnicity** Yoruba Hausa Ibo	384(95.5%) 12(3%) 6(1.5%)
Sex Male Female	265(65.9%) 137(34.1%)	**Religion** Christianity Islam Others	230(57.2%) 169(42.1%) 3(0.7%)
Level in School Junior School Senior School	82(20.4%) 320(79.6%)		

Table 1: Socio-demographic profiles of respondents

Among respondents, (78.2%) were aware that mental illness is not a punishments for bad deeds, (72.8%) know that is not as a result of lack of moral strength or will power and 76.1%, were aware that it was not developed to avoid difficult situation of life. In spite of the level of awareness, stigmatising attitude was high among adolescents as 69.7% would not be happy to sit next to this man in a bus, 79.6% would not eat food cooked by him, and 71.9% will avoid talking to him if possible. About 58.2% would not want him to teach their children, while 72.9% believe that most people in the community would do same thing they would do.

1. Exploratory Factor Analysis (EFA)

The EFA was conducted using data from the 402 respondents with complete information. The 4 items which measured social self-interest (SSI) in SSQ1 loaded on a factor and these had an alpha reliability coefficient of 0.91, items for evolutionary self-interest (ESI) also had high loading and a reliability coefficient of 0.72 while similar items loaded as psychological self-interest (PSI) and they had a reliability coefficient of 0.73. All the factors had reliability with alpha reliability coefficient of 0.82. Stigma attitude scale for the adolescent was constructed by summing up the items for each of the factors that loaded. Two of the subscales, ESI and SSI, contain four items each with scores ranging from 4 to16. One of the 5 items on the PSI scale 'Do you think this man is a bad person' had factor loading that was less clear however since there was not enough evidence to suggest the removal of the item, from the original 13 item questionnaire, a decision was taken to retain it in the over-all scale score despite the ambiguity. We therefore drew an impression on the reliability of the questionnaire even in our environment.

1. Factors associated with stigma

Variables	β	SE	df	F	p
Community Perception	.140	.049	1	8.149	**.001**
Type of school	.012	.049	1	.064	.800
Religion	-174	.053	2	10.661	.472
Tribe	.101	.050	2	4.013	.772
Level in School	.017	.059	1	.082	.775
Age	.011	.045	2	.088	**.002**
Gender	.156	.453	1	.935	**.010**

Table 2: Association between Stigma related attitude in the adolescents and some variables.

Multivariable analysis using categorical regressions indicated that socio-demographic variables such as type of school (p=0.800), religion (p=0.472), ethnicity (p=0.772), class in school (P=0.775) were not significantly associated with stigma related attitude in the adolescents in this study as shown in Table 2 above and thus are not predictors of stigma tendencies in the adolescents.

Table 3 shows the predictors of the stigma attitude in the adolescents; these are age, gender and community perception. Socio-demographic characteristic such as age which predicted stigmatisation was associated with the different components of stigma. Social self-interest which implies social distance decreased with age, whereas evolutionary and psychological self-interest increased with age. Mean score for overall stigma scale and the three factors were calculated and the result showed that younger adolescent (10-13years) had slightly higher overall stigma score than their older counterparts although this difference was not statistically significant. In comparing sample by gender, female respondents consistently had higher mean stigma scores across all three components than the male respondents and in all aspects of stigma had higher scores than male respondents. In these instances the scores were not statistically significant. Community perception was also an important predictor of the different component of stigma, but the effects vary across the components of stigma. The effect was more marked with social self-interest than for evolutionary and psychological self-interest. All components of stigmatisation showed significant association with community perception, age differences

Variables	Social self-interest *(P)OR,* [CI]	Evolutionary self-interest *(P)OR,* [CI]	Psychological Self- interest *(P)OR,* [CI]
Community Perception &No (not enacted)	**(<0.001) 1.60 [1.24-4.82]**	**(<0.001) 1.28 [1.12.-3.07]**	**(<0.012) 0.45 [0.14-0.95]**
Age (years) &(10-13)	**(<0.001) 0.50[0.20-0.86] 0.68 [0.10-0.90]**	**(<0.002) 1.04 [1.00 - 2.06] 1.52 [1.10-4.50]**	**(<0.046) 3.50 [1.95-8.53] 3.20 [1.10-9.50]**
Gender &(Female)	(<0.202) 0.61 [0.24 - 4.82]	(<0.215) 0.85 [0.33-1.12]	(<0.144) 0.45 [0.25-5.52]
&-Reference category			

Table 3: Logistic Regression analysis of various predictors of different components of stigma in the adolescent: OR and P-Values, CI.

5. Discussion

To the best of our knowledge, this is the first study to use the standardized stigmatisation questionnaire (SSQ1) to assess adolescents' stigmatising attitudes and their perception of community reaction towards people with mental illness in Sub-Saharan Africa. Earlier studies have either looked at stigma knowledge and attitudes among the adult population in the community or examined the perception of stigma by relatives of people with mental illness or were on a smaller scale [17]. Our result revealed a strong association between community perception and all components of stigma related attitude i.e., social self-interest, Evolutionary Self Interest and Psychological Self Interest and strongly support the writing and presentation of stigmatisation as a unitary characteristic [18, 19]. Our study found that social self-interest was highly influenced by community structure and its pursuit forms the basis of most of the stigmatisation in our environment upon which other components are built. This is comparable with findings in some previous studies in Europe which argued that the seeking of self-interest is the basis of most stigma if not all human behaviour [6] although a study from Australia upholds a multidirectional approach [20]. Stigmatising attitudes towards mental illness was highly prevalent among this representative sample of the adolescent population despite the high level of awareness and knowledge. However, a Previous study in Nigeria among adult population found that poor knowledge on the cause and nature of mental illness was common in the community and also established that negative attitude to mental illness were prevalent and may hinder the social integration of those with mental illness [17]. Our result. However,

showed that although knowledge or awareness was generally a good thing, it does not reduce all aspects of stigma this is because stigmatising attitudes is not based on a lack of knowledge about mental illness alone. These findings are in keeping with previous evidence that suggests that stigmatising attitudes are not always related to knowledge [21]. It follows, therefore, that effort to reduce stigma have to do more than increasing knowledge on the stigmatised conditions.

We also found that age and gender differences influenced adolescent stigmatisation of mental illness in this environment and as such, are factors which are strong enough to predict the tendency to stigmatise. Social self-interest showed a complex association with age as it decreases with increase in age while evolutionary and psychological self-interest increases with age suggesting that as people grow they tend to lean towards stigmatisation because of social, economic and psychological gain [6, 18]. Male adolescents were less likely to stigmatise mental illness than females in contrast to findings in earlier research in Australia [20] and North America [22].

Our finding supports those of earlier researchers who have suggested that societal structure to a large extent influence stigma related attitudes [1] while recognizing that there is a general human propensity to stigmatise those who are different [23]. We observed that responses on social self-interest suggesting social distance were significantly associated with community perception of stigma. According to Townsend when the difference between in-group and out-group is exaggerated it tends to obscure dissension within the in-group and promote in-group cohesion [6] leading the adolescent to act in a manner expected by the community (in-group) by exhibiting stigmatising attitudes for the social self-interest of others, while the adolescent as an independent individual may not be inclined towards stigmatisation. Since social and environmental forces shape the personality of the adolescent within the societal structure that he/she is a member and social distancing ensures a continuing lack of familiarity with the realities of sufferers of mental illnesses, [24] we can infer that the direction of influence is from the community to adolescents. Efforts to reduce stigmatisation should, therefore, focus also on the societal structure. Our finding, therefore, supports an earlier suggestion in a previous study that young people and their parents should be involved in efforts to reduce societal stigmatising attitudes [24].

Our study has several limitations: causal interpretation of the findings is limited by the cross-sectional nature of the data and the fact that we cannot generalize the findings to the whole of Sub-Saharan Africa due to the diversity in the traditional

societal structure. The strength of this study was its use of the standardised stigmatisation questionnaire in assessment of stigmatisation from the perspective of social self-interest, evolutionary self-interest and psychological self-interest pointing at the roots of stigmatisation and where to direct efforts for intervention. In addition, the study comes from a region where adolescents stigmatising attitudes has not been previously well studied.

In conclusion, the findings presented here provide a beginning for further research into societal structure and its effect on adolescents' stigma related attitude towards mental illness. We have shown that the components of stigma all have roots in social self-interest. We also showed that age, gender differences and community perception all have an influence on stigma. Stigmatisation of mental illness by adolescents is high in our environment; it is greatly influenced by the community structure, and it goes deeper than lack of knowledge. Stigma reduction effort should aim not just at educational intervention for the adolescent but should also target the societal structure.

References

[1] A. J. Gray, Stigma in psychiatry, *Journal of the Royal Society of Medicine*, **95**, no. 2, 72–76, (2002).

[2] J. L. Hilton and W. Von Hippel, Stereotypes, *Annual Review of Psychology*, **47**, 237–271, (1996).

[3] C. M. Judd and B. Park, Definition and assessment of accuracy in social stereotypes, *Psychological Review*, **100**, no. 1, 109–128, (1993).

[4] J. Krueger, Personal Beliefs and Cultural Stereotypes about Racial Characteristics, *Journal of Personality and Social Psychology*, **71**, no. 3, 536–548, (1996).

[5] P. Corrigan W, Waston A C, in *Understanding the impact of stigma on people with mental illness World Psychiatry*, **1**, 16–20, Understanding the impact of stigma on people with mental illness World Psychiatry, 2002.

[6] R. Haghighat, The Development of an Instrument to Measure Stigmatization: factor analysis and origin of stigmatization, *The European Journal of Psychiatry*, **19**, no. 3, (2005).

[7] M. F. Weiss, Children's attitudes toward the mentally ill: an eight-year longitudinal follow-up., *Psychological Reports*, **74**, no. 1, 51–56, (1994).

[8] O. Wahl, Childrens views of mental illness: a review of the literature. Psychiatr Rehabilitation Skills, in *Children's views of mental illness: a review of the literature. Psychiatr Rehabilitation Skills*, 134–158, 6, 134–158, 2002.

[9] P. W. Corrigan, B. D. Lurie, H. H. Goldman, N. Slopen, K. Medasani, and S. Phelan, How adolescents perceive the stigma of mental illness and alcohol abuse, *Psychiatric Services*, **56**, no. 5, 544–550, (2005).

[10] A. C. Watson, E. Otey, A. L. Westbrook, A. L. Gardner, T. A. Lamb, P. W. Corrigan, and W. S. Fenton, Changing middle schoolers' attitudes about mental illness through education, *Schizophrenia Bulletin*, **30**, no. 3, 563–572, (2004).

[11] A. C. Watson, F. E. Miller, and J. S. Lyons, Adolescent attitudes toward serious mental illness, *The Journal of Nervous and Mental Disease*, **193**, no. 11, 769–772, (2005).

[12] P. W. Corrigan and D. L. Penn, Lessons from social psychology on discrediting psychiatric stigma, *American Psychologist*, **54**, no. 9, 765–776, (1999).

[13] P. W. Corrigan, A. Green, R. Lundin, M. A. Kubiak, and D. L. Penn, Familiarity with and social distance from people who have serious mental illness, *Psychiatric Services*, **52**, no. 7, 953–958, (2001).

[14] M. C. Angermeyer, H. Matschinger, and P. W. Corrigan, Familiarity with mental illness and social distance from people with schizophrenia and major depression: Testing a model using data from a representative population survey, *Schizophrenia Research*, **69**, no. 2-3, 175–182, (2004).

[15] V. Pinfold, H. Toulmin, G. Thornicroft, P. Huxley, P. Farmer, and T. Graham, Reducing psychiatric stigma and discrimination: Evaluation of educational interventions in UK secondary schools, *The British Journal of Psychiatry*, **182**, 342–346, (2003).

[16] B. Schulze, M. Richter-Werling, H. Matschinger, and M. C. Angermeyer, Crazy? So what! Effects of a school project on students' attitudes towards people with schizophrenia, *Acta Psychiatrica Scandinavica*, **107**, no. 2, 142–150, (2003).

[17] O. Gureje, V. O. Lasebikan, O. Ephraim-Oluwanuga, B. O. Olley, and L. Kola, Community study of knowledge of and attitude to mental illness in Nigeria, *The British Journal of Psychiatry*, **186**, 436–441, (2005).

[18] R. A. Haghigat, Unitary Theory of stigmatization, *Br J Psychiatry*, 178–207, (2001).

[19] R. A. Haghigat, Unitary Theory of stigmatization, *Br J Psychiatry*, 178–378, (2001).

[20] A. F. Jorm and A. Wright, Influences on young people's stigmatising attitudes towards peers with mental disorders: National survey of young Australians and their parents, *The British Journal of Psychiatry*, **192**, no. 2, 144–149, (2008).

[21] P. Byrne, Psychiatric stigma: Past, passing and to come, *Journal of the Royal Society of Medicine*, **90**, no. 11, 618–621, (1997).

[22] A. Chandra and C. S. Minkovitz, Stigma starts early: Gender differences in teen willingness to use mental health services, *Journal of Adolescent Health*, **38**, no. 6, 754–e8, (2006).

[23] P. Gilbert, Stigmatization as a survival strategy: skeletons in the cupboard and the role of shame, in *In Every Family in the Land: Tackling Prejudice and Discrimination against People with Mental Illnesses*, A. H Crisp, Ed., and the role of shame. In Every Family in the Land, Tackling Prejudice and Discrimination against People with Mental Illnesses, 2000, www.stigma.org.

[24] A. H. Crisp, M. G. Gelder, S. Rix, H. I. Meltzer, and O. J. Rowlands, Stigmatisation of people with mental illnesses, *The British Journal of Psychiatry*, **177**, 4–7, (2000).